STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675226	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stevens Nursing and Rehabilitation Center of Halle	106 Kahn St 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 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 prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen observed for food and nutrition services. The facility failed to ensure dietary staff maintained proper hand hygiene during meal service. These failures could place residents at risk for food borne illness. Findings included: During an observation on 04/30/2026 at 11:54 a.m. Dietary Aide A was observed to assist with tray preparation for the secure unit. When the trays were ready to leave the kitchen on the meal cart Dietary Aide A was observed opening the kitchen door, picking up the phone on the kitchen wall, and paged out letting staff know the trays were ready for the secure unit. Dietary Aide then pushed the tray cart out into the dining room; after grabbing a chair from the dining room to hold the door up as he pushed the trays out Dietary Aide A was then observed to wipe his nose with his hand and returned to the kitchen and did not wash his hands before returning to the line and began assisting with prepping the trays for rest of the halls. While preparing the trays, Dietary Aide A was observed placing butter packets/drinks on the trays and grabbing plates that had been prepared placing on trays and placing the insulated lids on the plates. During an observation on 04/30/2026 at 12:02 p.m. Dietary Aide A while he continued to prepare trays was observed to scratch the side of his nose and did not wash his hands. During an interview on 04/30/2026 at 12:53 p.m. Dietary Aide A stated he was not aware he had wiped his nose, while he was holding the door of the kitchen after taking the secure unit trays out of the kitchen. Dietary Aide A further stated after he paged using the phone, opening the door, moving the chair to prop the door so he could get out of the kitchen with the meal he should have washed his hands when he came back in the kitchen due to it could cause cross contamination. Dietary Aide A stated someone could possibly get sick from cross contamination. During an interview on 04/30/2026 at 5:40 p.m. the Dietary Manager stated the Dietary Aide should have gone to the sink and washed his hands because from the dining room to the kitchen that was cross contamination. The Dietary Manager stated cross contamination could have occurred because he could have picked up germs from something he touched, and it could be passed on to the trays which could possibly make the residents sick. Record review of kitchen staff food handlers revealed all staff with their food handlers with Dietary Aide A having completed his 11/20/2025 with effective date of 11/20/2025 expiring 2 years after the effective date. Record review of facility's policy, Hand Washing, approved October 1, 2018, read, Policy: The facility recognized that food-borne illness has the potential to harm elderly and frail residents. All Nutrition and Foodservice employees will practice good hand-washing practices in order to minimize the risk of infection and food borne illness. Procedure: 2. Hands should be washed after the following occurrences: c. Touching the hair, face, or body. k. Touching un-sanitized equipment, work surfaces. Record review of facility's policy, Employee Sanitation, approved date October 1, 2018, read Policy: The Nutrition & Foodservice employees of the facility will practice good sanitation practices in accordance with the state and US Food Codes in order to minimize the risk of infection and food borne illness. Procedure: 5. Hand washing a. Employees must wash their hands and exposed portions of their arms at designated hand-washing facilities at the following times: i. After touching bare human body parts other than clean hands and clean, exposed (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	portions of arms. v. During food preparation, as often as necessary to remove soil and contamination and prevent cross contamination when changing tasks. vii. After engaging in other activities that contaminate the hands.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** Based on observation, interview and record review the facility failed to provide pharmaceutical services (including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 1 medication room (main medication room) and 1 of 3 medication carts (100-hall nursing cart) reviewed and 1 of 1 Resident (Resident #20) reviewed for medication storage. 1. The facility failed to ensure an expired packet (total 15 tablets) of gas relief (simethicone 125 mg) was not stored inside the main medication room on 04/29/2026. The medication expired on 02/2025. 2. The facility failed to ensure an expired bottle of cream compound (Ketamine 10%, Diclofenac 5%, and Gabapentin 6% cream) was not stored inside the 100-hall nursing cart on 04/29/2026. The medication expired on 02/11/2026. 3. The facility failed to ensure the blood pressure instructions on Resident #20's blister packet of Lisinopril, for high blood pressure, matched the resident's primary care physician order. These failures could place residents at risk of not receiving therapeutic doses of their medication. Findings include:1. Observation on 04/29/2026 at 4:17 p.m. revealed inside the main medication room, there was one packet (total 15 tablets) of Simethicone 125 mg for gas relief on the shelf, and the medication was expired 02/2025. Interview on 04/29/2026 at 4:19 p.m., the ADON stated there was one packet (total 15 tablets) of gas relief (simethicone 125 mg) inside the main medication room, and it was expired on 02/2025. The ADON said the facility nurse removed the medication from residents and put the medication on the shelf inside the main medication room, and it was wrong because the facility nurses should have discarded it to the discontinued medication box. The ADON stated facility nurses had responsibility regarding discarding all expired medications immediately to prevent possible use and adverse effects. 2. Observation on 04/29/2026 at 4:34 p.m. revealed inside 100-hall nursing cart, there was one bottle of cream compound, and the cream compound was made up with Ketamine 10%, Diclofenac 5%, and Gabapentin 6% cream, and the cream had the label, and the label said, Do not use beyond 02/11/2026. Interview on 04/29/2026 at 4:41 p.m., the ADON said there was one bottle of cream compound (Ketamine 10%, Diclofenac 5%, and Gabapentin 6% cream) inside the 100-hall nursing cart, and it expired on 02/11/2026. The ADON said this medication belonged to the resident who was already discharged from the facility, so all facility nurses should have discarded this medication to the discontinued medication box to prevent possible use and adverse effects. 3. Record review of Resident #20's face sheet, dated 05/01/2026, revealed an [AGE] year-old female who was originally admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Resident #20 had diagnoses which included spinal stenosis (the narrowing of one or more spaces within the spinal canal), hypertension (high blood pressures), and dementia (loss of memory and thinking ability). Record review of Resident #20's quarterly MDS assessment, dated 03/30/2026, revealed the resident's BIMS score was 13 out of 15, which indicated the resident's cognition was intact. Resident #20 had hypertension (high blood pressures) as an active diagnosis. Record review of Resident #20's comprehensive care plan, dated 08/01/2025, revealed the resident had the care plan of [Resident #20] has altered cardiovascular status related to hypertension (high blood pressures). For intervention - Monitor vital signs. Notify physician of significant abnormalities. Record review of Resident #20's physician order, start dated 02/17/2026, revealed the resident had the order of Lisinopril Oral Tablet 20 MG (Lisinopril) Give 1 tablet by mouth one time a day related to essential (primary)hypertension and Hold for Blood Pressure less than 110. Record review of Resident #20's medication administration record, from 04/01/2026 to 04/30/2026, revealed the resident was receiving her Lisinopril Oral Tablet 20 MG (Lisinopril) 1 tablet by mouth one time a day for hypertension at 8:00 AM as ordered. Observation on 04/30/2026 at 8:38 a.m. revealed MA-C measured Resident #20's blood pressure before giving the resident's Lisinopril, and the resident's blood (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure was 149/73 and heart rate was 54 per minute (normal range for blood pressure was 120/80 and pulse was from 60 to 100 per minute). MA-C hold Resident #20's Lisinopril and notified the charge nurse because the label on the resident's Lisinopril blister packet indicated Hold if blood pressure was less than 110 or heart rate was less than 60 per minute. Interview on 04/30/2026 at 8:40 a.m., MA-C stated she held Resident #20's Lisinopril because the resident's heart rate was 54 per minutes, and the label on the medication blister packet said, Hold if blood pressure less than 110 or heart rate less than 60 and notified the charge nurse regarding holding the medication and the resident's heart rate. Further interview on 05/01/2026 at 10:31 a.m. with the MA-C said she knew Resident #20's physician order said, Hold if blood pressure less than 110, but the label on the medication blister packet said, Hold if blood pressure less than 110 or heart rate less than 60, but she followed the label, instead of following the physician order. MA-C stated she should have asked the difference between the physician order and the label on the blister packet to the charge nurse and followed the physician order, but she said she did not report it to the nurse because Resident #20's heart rates were usually more than 60 per minutes. Interview on 04/30/2026 at 11:11 a.m., LVN-D said she contacted Resident #20's primary care physician and reported regarding the difference between the physician order (hold Lisinopril if blood pressure less than 110) and label on the blister packet (hold Lisinopril if blood pressure less than 110 or heart rate less than 60), and the physician said the facility nurse and MA should hold Resident #20's Lisinopril if only the resident's blood pressure was less than 110, not heart rate. LVN-D said she gave Lisinopril to Resident #20 because the resident's blood pressure was more than 110 as ordered and contacted the pharmacy and said the label on the blister packet was incorrect. Interview on 04/30/2026 at 11:16 a.m. with the DON said if the facility nurse or MA already knew the difference between the physician order (hold Lisinopril if blood pressure less than 110) and label on the blister packet (hold Lisinopril if blood pressure less than 110 or heart rate less than 60), they should have asked the resident's primary care physician and pharmacy and should have tried to fix the inaccurate label to prevent confusion and the resident might not take the medication as ordered and should have returned or destroyed the items per the facility policy. Record review of the facility's policy, titled Medication Storage and Disposal - expiration dating and expired medications, revised 10/01/2019, revealed . 8. It is the responsibility of all nurses who administer medications to monitor the expiration dates of the medications. Expired medications will not be administered in the facility. All expired medications will be disposed of per facility policy.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure any irregularities reported by the pharmacist to the attending physician, the facility's medical director , and the director of nursing were acted upon for 1 of 5 residents (Resident #35) reviewed for medications. The facility failed follow the facility's Pharmacy Consultant Recommendation for Resident #35's lipid panel (a blood test that measures the amount of fat molecules called lipid in the blood) order due to Simvastatin for high cholesterol. The resident's physician agreed with the recommendation on 04/06/2026. This failure could place residents at risk for adverse consequences and could cause a decline in their physical, mental, and psychosocial condition. The findings were: Record review of Resident #35's face sheet, dated 05/01/2026, revealed a 64-years-old female who was originally admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Resident #35 had diagnoses which included pure hypercholesterolemia (lipid disorder in which low-density lipoprotein, or bed cholesterol, is too high), moderate intellectual disorder (a person has certain limitation in cognitive functions and skills including conceptual, social and practical skills, such as language, social, and self-care skills), and bipolar disorder (a mental health condition that causes extreme mood swings). Record review of Resident #35's annual MDS assessment, dated 04/16/2026, revealed the resident's BIMS score was 3 out of 15, which indicated the resident had severe cognitive impairment. Resident #35 had a diagnosis of hyperlipidemia (high cholesterol). Record review of Resident #35's comprehensive care plan, dated 11/04/2019, revealed the resident had the care plan of [Resident #35] has hypercholesterolemia. For intervention - Give medication for hypertension and document response to medication and any side effects, Give meds to control cholesterol level as ordered by the physician, and lab work to be done as ordered by physician. Record review of Resident #35's physician orders, dated 06/18/2025, revealed the resident had the order of Simvastatin Oral Tablet 40 MG (Simvastatin) - Give 1 tablet by mouth one time a day related to pure hypercholesterolemia. Record review of Resident #35's medication administration record from 04/01/2026 to 04/30/2026 revealed the resident was receiving her Simvastatin Oral Tablet 40 MG (Simvastatin) 1 tablet by mouth one time a day at 7:00 PM as ordered. Record review of Resident #35's Consultant Pharmacist/Physician Communication, dated 04/03/2026, revealed the facility pharmacist recommended [Resident #35] has an order for Simvastatin. Please consider a Lipid Panel. Further record review of the Consultant Pharmacist/Physician Communication revealed the resident's primary care physician agreed on 04/06/2026. Record review of Resident #35's medical record from 04/06/2026 to 05/01/2026 revealed there was no record regarding the facility conducted Resident #35's blood test for Lipid Panel. Interview on 05/01/2026 at 9:58 a.m., the ADON said Resident #35's pharmacist recommended a Lipid Panel on 04/03/2026, and the resident's physician agreed on 04/06/2026, but the facility did not conduct the resident's Lipid Panel because she forgot , and it was her mistake. Making sure the follow-ups regarding pharmacist and physician recommendations was ADON and DON's responsibility, and at this time there was no potential negative harm because the resident was taking Simvastatin every day as ordered and no complications about high cholesterol, such as heart attack or stokes. Interview on 05/01/2026 at 1:00 p.m., the DON said the facility should have conducted Resident #35's Lipid Panel because the pharmacist recommended it and the physician agreed. The DON stated she contacted the resident's physician and received the order for conducting the Lipid Panel on 05/20/2026, and the facility did not have the policy regarding follow-up to the pharmacist and physician recommendations.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable and failed to ensure in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for 1 of 8 residents (Resident #57) reviewed for medication storage and labels. 1. The facility failed to ensure nurses put a normal saline 10 cc syringe in the cart, instead of leaving it unattended on the nightstand inside Resident #57's room. This failure could place residents at risk of not having medications as ordered due to diversion of medication and incorrect instructions. Findings include: 1. Record review of Resident #57's face sheet, dated 05/01/2026, revealed a 92-years-old male who was originally admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Resident #57 had diagnoses which included chronic obstructive pulmonary disease (common lung disease causing restricted airflow and breathing problems), muscle wasting and atrophy (loss of skeletal muscle mass), and Alzheimer's disease (progressive disease that destroy memories and other important mental functions). Record review of Resident #57's quarterly MDS assessment, dated 01/21/2026, revealed the resident's BIMS score was 5 out of 15, which indicated the resident had severe cognitive impairment and required Partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) to sit to stand, chair to bed, and toilet transfer. Record review of Resident #57's comprehensive care plan, dated 01/26/2026, revealed the resident had the care plan of Needs structured environment in secure unit related to cognitive deficit for Alzheimer's disease. For intervention - Provide low stimulation environment. Observation on 04/28/2026 at 11:51 a.m. revealed there was one 10 cc syringe of normal saline on the nightstand inside Resident #57's room unattended. Interview on 04/28/2026 at 12:39 p.m., LVN-B said there was one 10 cc syringe of normal saline on the nightstand inside Resident #57's room unattended, and it was unacceptable because it should have been stored inside the nursing cart. LVN-B stated she did not know what reason the 10 cc normal saline syringe was on the nightstand inside the resident's room unattended, and the resident and other residents with Alzheimer's disease or dementia might eat it because they were confused. Interview on 04/30/20206 at 5:15 p.m., the DON said the facility nurse should have stored 10 cc normal syringe inside the nursing carts to prevent possible use from confused residents, and it was the facility nurses' responsibilities. Record review of the facility's policy, titled Medication Ordering, Receiving, and Storage, dated 05/01/2020, revealed . 3. If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption, for 1 of 8 residents (Residents #57) reviewed for food and nutrition services. The facility failed to ensure foods stored in Resident #57's personal refrigerator were labeled and dated. The failure could place residents at risk for food borne illness. The findings include:Record review of Resident #57's face sheet, dated 05/01/2026, revealed a 92-years-old male who was originally admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Resident #57 had diagnoses which included chronic obstructive pulmonary disease (common lung disease causing restricted airflow and breathing problems), muscle wasting and atrophy (loss of skeletal muscle mass), and Alzheimer's disease (progressive disease that destroy memories and other important mental functions). Record review of Resident #57's quarterly MDS assessment, dated 01/21/2026, revealed the resident's BIMS score was 5 out of 15, which indicated the resident had severe cognitive impairment and required Partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) to sit to stand, chair to bed, and toilet transfer. Record review of Resident #57's comprehensive care plan, dated 04/27/2026, revealed the resident had the care plan of [Resident #57] has potential nutritional problem and is at risk for complications related to history of weight loss. Risk for malnutrition related to impaired cognition and Poor appetite, refuses some meals. Diet: Regular diet Regular texture,Regular Liquids. For intervention - Offer substitute if dislikes meal served and provide and serve diet as ordered. Observation on 04/28/2026 at 11:51 a.m. revealed there was a personal refrigerator in the room, and inside the refrigerator there was food wrapped in plastic wrap for food, but no date and no label on the wrap. Interview on 04/28/2026 at 12:39 p.m., LVN-B stated the food inside Resident #57's refrigerator was bread, and the resident's family might bring the food, but the food did not have any label and date. LVN-B said she did not know how long the food was inside the refrigerator because there was no label and date, and the nurse said the facility night nurses had the responsibility regarding checking it every day to prevent possible food-born illness. Interview on 04/30/2026 at 5:18 p.m., the DON stated the facility nurses were responsible for overseeing Resident #57's personal refrigerator and also responsible for monitoring it daily and should have dated and labeled to the food that the family member brought. The DON stated the resident might have food illness. Record review of the facility's policy, titled Use and Storage of Food Brought in by Family or Visitors, dated 01/27/2023, revealed . 2. All food items that are already prepared by the family or visitors brought in must be labeled with content and dated.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained that were complete and accurately documented for 1 of 8 residents (Resident #8) reviewed for clinical records. The facility failed to ensure Resident #8's diagnosis of major depression was updated in the residents medical record. This deficient practices could result in errors in care and treatment. The findings were: Record review of Resident #8's face sheet, dated 05/01/2026, revealed a 90-years-old female who was admitted to the facility on [DATE]. Resident #8 had diagnoses which included dementia (loss of memory and thinking ability), muscle wasting and atrophy (loss of skeletal muscle mass), and type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels). Record review of Resident #8's significant change in status MDS assessment, dated 04/14/2026, revealed the resident's BIMS score was 3 out of 15, which indicated the resident had severe cognitive impairment and was receiving antidepressant in Section N (Medications). Record review of Resident #8's comprehensive care plan, dated 04/19/2026, revealed the resident had the care plan of [Resident #8] uses psychotropic medications Citalopram and Rexulti for Anxiety. For intervention - Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every-shift. Record review of Resident #8's physician order, start dated 01/07/2026, revealed the resident had the order of Citalopram Hydrobromide Oral Tablet 10 MG (Citalopram Hydrobromide) Give 2 tablet by mouth one time [NAME] for Depression related to Major Depressive Disorder, Recurrent, Moderate. Give 2 tabletsto equal 20mg. Record review of Resident #8's Psychiatric Periodic Evaluation, dated 01/07/2026, revealed Resident #8's psychiatric doctor gave the diagnosis of Major depressive disorder to the resident and started Citalopram Hydrobromide for the major depression. Record review of Resident #8's medical record from 04/23/2025 to 05/01/2026 revealed there was no diagnosis of Major depression disorder in the resident's medical record. Interview on 05/01/2026 at 11:00 a.m., the DON said Resident #8 received her Citalopram Hydrobromide for major depression disorder, and the facility nurses should have updated the diagnosis into the resident's medical record when it was changed and added, and inaccurate medical record might affect incorrect care to the resident, and the facility did not have a policy regarding medical record accuracy, but medical records should be accurate and reflect the resident's current status.