

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675866	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2025
NAME OF PROVIDER OR SUPPLIER Stephenville Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2311 West Washington Stephenville, TX 76401	
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to properly store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed. The facility failed to ensure food items out of original containers were dated and labeled. The facility failed to ensure the Vegetable Freezer and the Meat Freezer's temperatures were taken and recorded on 09/20/2025, 09/21/2025, 09/22/2025 and 09/23/2025. These failures could place residents at risk for food borne illnesses. Findings included: During an observation on 9/23/2025 between 9:30 AM and 10:00 AM of the kitchen revealed: Freezer #1:3 packages of bologna that did not have a date1 package of Ham that did not have a date Freezer #2:1 bag of egg rolls out of the original container that was not sealed and did not have a date Vegetable Freezer:The temperature log for the Vegetable Freezer revealed no temperature checks for 9/20/2025, 9/21/2025, 09/22/2025, and 09/23/2025 were completed. 3 bags of Zucchini out of original container that was not labeled with a date3 bags of breaded okra out of original container that was not labeled with a date. Meat Freezer:The temperature log for the Meat Freezer revealed no temperature checks for 9/20/2025, 9/21/2025, 09/22/2025, and 09/23/2025 were completed. During an interview on 09/23/2025 at 10:00 AM, the DM stated her expectation was that all freezers were checked daily, and the temperatures logged on the temperature log daily. The DM stated food items out of original container should have been labeled with a received date, expiration date, and an item description. The DM stated dietary staff were responsible to take records temperatures and labelling food items. The DM stated she was responsible for monitoring staff and monitored by making random checks. The DM stated residents could have been affected by receiving food that might have been spoiled. The DM stated what led to failure was new kitchen staff. During an interview on 09/25/2025 at 10:43 AM, the ADMN stated her expectation was that food was labeled per policy and that freezer temperatures were to be taken and recorded daily. The ADMN stated dietary staff were responsible for labeling food and taking and recording freezer temperatures daily. The ADMN stated the DM was responsible for monitoring dietary staff. The ADMN stated residents could have been affected by poor food safety. The ADMN stated what led to failure was a new cook did not record freezer temperatures and oversight by staff for not labeling food items per policy. Record review of facility policy titled, Food Storage, dated 1/1/2025 revealed, Food storage practices will follow Centers for Medicare & Medicaid Services (CMS), Food and Drug Administration (FDA) Food Code, and state/local health department requirements. All foods must be covered, labeled, and dated upon receipt and after opening. Thermometers must be placed in freezers, checked, and logged at least daily. Review of the FDA Food Code 2022 https://www.fda.gov/food/retail-food-protection/fda-food-code accessed 09/25/2025 revealed: 3-602.11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. (B) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement; (2) If made from two or more ingredients, a list of ingredients and sub-ingredients in descending order of predominance by (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	weight, including a declaration of artificial colors, artificial flavors and chemical preservatives, if contained in the FOOD. (3) An accurate declaration of the net quantity of contents; (4) The name and place of business of the manufacturer, [NAME], or distributor; and (5) The name of the FOOD source for each MAJOR FOOD ALLERGEN contained in the FOOD unless the FOOD source is already part of the common or usual name of the respective ingredient. (6) Except as exempted in the Federal Food, Drug, and Cosmetic Act S 403(q)(3) - (5), nutrition labeling as specified in 21 CFR 101 - Food Labeling and 9 CFR 317 Subpart B Nutrition Labeling.		

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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. 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 reviewed for 2 of 2 residents (Resident #13 and Resident #25) and 2 of 2 staff (CNA A and CNA B) reviewed for infection control. The facility failed to ensure proper infection prevention techniques were used by CNA A when providing peri-care by not performing hand hygiene before and after peri-care for Resident #13. The facility failed to ensure proper infection prevention techniques were used by CNA A when providing peri-care by utilizing the same soiled wipe several times to clean the peri area for Resident #13. The facility failed to ensure proper infection prevention techniques were used when CNA A failed to follow peri-care standards of practice when going from dirty to clean for Resident #13. The facility failed to ensure proper infection prevention techniques were used by CNA B when providing peri-care by utilizing the same soiled wipe several times to clean the peri area for Resident #25. The facility failed to ensure proper infection prevention techniques were used when CNA B failed to follow peri-care standards of practice when going from dirty to clean for Resident #25. The facility failed to ensure proper infection prevention techniques were used by CNA B when providing peri-care by applying cream to peri-area with contaminated gloves for Resident #25. Findings included: During an observation on 09/24/2025 at 1:20 PM, CNA A wheeled Resident #13 into the shower room. CNA A donned gloves with no hand hygiene prior. CNA A assisted resident to a standing position while resident held on to a grab bar. CNA A removed Resident #13's brief and placed it in the trash can. CNA A wiped resident from front to back down the labia. CNA A then wiped again down right groin and then wiped again down left groin, all with the same wipe. CNA A discarded wipe and did not remove gloves. CNA A then placed clean brief on the resident. CNA A removed gloves and wheeled the resident out of the shower room with no hand hygiene. During an observation on 09/24/2025 at 2:35 PM, CNA B entered Resident #25's room. CNA B sanitized hands and donned gloves. CNA B assisted resident to bed using a gait belt. CNA B unfastened Resident #25's brief and tucked it between the resident's legs. CNA B wiped front to back down resident's labia. CNA B then folded the wipe and wiped right groin then folded wipe and wiped left groin. CNA B stuffed wipe in between the resident's legs in the brief. CNA B rolled the resident over, did not wipe buttocks and removed brief. CNA B did not change gloves or sanitize hands. CNA B placed a new brief and rolled resident back over. CNA B applied cream to resident's labia with unchanged gloves. Record review of personnel files on 09/25/2025 showed no evidence of skill competency checkoffs for CNA A. Further review revealed infection control training in February 2025. Record review of personnel files on 09/25/2025 showed no evidence of skill competency checkoffs for CNA B. Further review revealed infection control training in February 2025. During an interview on 09/25/2025 at 10:20 AM, the ADON stated that hands should have been washed prior to and after peri-care. She stated gloves should have been changed and hands sanitized before applying a clean brief. ADON stated that gloves should have been changed, and hands sanitized prior to applying any cream to a clean peri-area. During an interview on 09/25/2025 at 10:30 AM, the Administrator stated her expectation was for peri-care to be performed correctly and all infection-control policies be followed. She stated hands should always be washed before and after; and cleaning should always be worked from dirty to clean. She stated that yearly competencies were completed with all staff. She stated the DON and ADON were responsible to ensure competencies were completed. She stated this failure could lead to the spread of infection. Review of facility's policy titled Perineal Care, dated 01/01/2025 revealed: Policy: It is the practice of this facility to provide perineal care to all incontinent residents during bath and as needed in order to promote cleanliness and comfort, prevent infection to the extends possible, and to prevent and assess from skin breakdown. Policy Explanation and Compliance Guidelines.2. Gather supplies as needed.b. Disposable Cleaning Cloth Method.6. Perform hand hygiene and put on gloves. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. Females.b. open package and obtain the wet cloth. Separated the residents' labia with one hand, and cleanse perineum with the other hand by wiping in direction from front to back. D. Repeat on opposite side using a new disposable wipe. E. Clean urethral meatus and vaginal orifice using a new disposable wipe with each stroke. 16> Remove gloves and discard. Perform hand hygiene.		

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to post in a place readily accessible to residents, and family members and legal representative of residents, the results of the most recent survey of the facility including any plans of correction without identifying information about complainants or residents reviewed for resident rights affecting 40 residents. The facility failed to ensure the three preceding years of any surveys, certifications, and complaint investigations with plans of correction were posted for residents, family members, and visitors to review without identifying information about complainants or residents. This failure could place residents at risk for not reviewing the findings from State surveys and investigations conducted in the facility without asking to review the reports. Findings included: During an observation and record review on 09/25/2025 at 9:45 AM, the last State survey results, plan of correction, and report of contact dated 04/14/2022, were in a black 3-ring binder in a wall pocket located by the main entrance door. During an interview on 09/25/2025 at 10:42 AM, the Administrator stated the policy was for recent survey results to be made available for public review with signage indicating where to locate the results. She stated her expectations were for the results to be in the binder. The Administrator stated she asked the BOM recently to check the binder and was told by the BOM the survey results were by the front door. The Administrator could not answer why the required survey results were not included in the binder. The Administrator explained the effect on residents may be if a resident wanted to review the results, they would not be able to. The Administrator stated she was responsible for ensuring the results were available. During an interview on 09/25/2025 at 10:51 AM, the BOM stated she started in her current position six weeks ago. She recalled the Administrator asked her to check the binder. She stated she only checked to make sure the binder was in the wall pocket. She stated she did not open the binder to verify the dates on the survey results. The BOM stated the Administrator was responsible for maintaining the survey results binder. She was unable to state what effect the failure to make the survey results available had on residents. Review of facility policy titled Facility Required Postings, dated 01/01/2023, revealed 2. The facility must also post the following: . j. Most Recent Survey Results of the Facility.		