STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676213	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hewitt Nursing and Rehabilitation	8836 Mars Dr Hewitt, TX 76643

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 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. (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 0842 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 ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete and accurately documented for 1 of 5 residents (Resident #1) for complete and accurate records. The facility failed to ensure Resident #1's nothing by mouth was documented in PCC for December 20th and December 21st on the 10:00 PM -6:00 AM shift. This failure could place residents at risk for the possibility of not verifying the needed care and services to meet their needs. Findings include:A record review of Resident #1's face sheet, dated 12/22/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included type 2 diabetes(body does not make enough insulin), heart failure(heart can't pump enough oxygen-rich blood to meet the body's need), dysphagia(difficulty swallowing food or liquid), and hypertension(high blood pressure).A record review of Resident #1's care plan, dated 12/22/2025, reflected Resident #1 required tube feeding.A record review of Resident #1's Quarterly MDS assessment, dated 09/01/2025, reflected Resident #1 had BIMS score of 99, which indicated unable to complete the interview.A record review of Resident #1's physician's order dated 03/05/2025 reflected NPO every shift start date 03/05/2025.A record review of Resident #1's MAR dated 12/20/2025 and 12/21/2025 reflected NPO was not signed off by LVN A on the 10:00 PM - 6:00 AM shift.Observation of Resident # 1 on 12/22/2025 at 2:00 PM revealed the resident was lying in bed asleep.Attempted an interview with Resident # 1's RP on 12/22/2025 at 12:00 PM, 2:30 PM, and 5:30 PM. Resident # 1's RP was not able to be contacted by exit on 12/22/2025.Attempted an interview with LVN A on 12/22/2025 at 3:38 PM, 4:02 PM, and 5:25 PM. Left LVN A voice messages each attempt and LVN A did not respond back by exit on 12/22/2025.During an interview with the DON on 12/22/2025 at 4:35 PM, the DON stated it was expected for LVN A to have signed off on the MAR on 12/20/2025 and 12/21/2025 on the 10:00 PM- 6:00 AM shift. The DON stated when the MAR was not signed off would indicate it was not done.During an interview with the ADM on 12/22/2025 at 5:19 PM, the ADM stated it was expected for LVN A to have signed off on Resident # 1's MAR to ensure documentation was completed. The ADM stated if the MAR was not signed off on would have indicated that it was not completed and could cause further complications. Record review of the facility's, revised 07/2017, policy titled Charting and Documentation reflected All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response care. 7.Documentation of procedures and treatments will include care-specific details including:A. The date and time the procedure/treatment was providedB. The name and title of the individual(s) who provided the careC. The assessment data and/or any unusual findings obtained during the procedure/treatmentD. How the resident tolerated the procedure/treatmentE. Whether the resident refused the procedure/treatmentF. Notification of family, physician or other staff, if indicated; andG. The signature and title of the individual documenting.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 5 residents (Resident #2) reviewed for infection control practices.The facility failed to ensure Resident #2's soiled wash cloth was removed from the bedside table on 12/22/2025The facility failed to ensure Resident # 2's urinal bottle was emptied on 12/22/2025. This failure placed residents at risk of cross contamination. Findings included:Record review of Resident #2's face sheet dated 12/22/2025 reflected a [AGE] year-old male admitted to the facility on [DATE]. Resident #2 had diagnoses which included congestive heart failure(heart can't pump enough oxygen-rich blood to meet the body's need),Type 2 diabetes(body does not make enough insulin)and hypertensive heart disease(heart problems from long term high blood pressure).Record review of Resident #2's care plan dated 12/22/2025, reflected Resident #2 exhibited ADL self-care performance deficit that required assistance with ADL's which included intervention of self-performance extensive support.A record review of Resident #2's Quarterly MDS assessment, dated 10/01/2025, reflected Resident #2 had BIMS score of 15 indicating the resident was cognitively intact. Observation on 12/22/2025 at 9:34 AM., revealed Resident #2's soiled wash cloth was sitting on the bedside table.Observation on 12/22/2025 at 9:34 AM., revealed Resident #2's urinal bottle sitting on bedside table filled to the top of the urinal bottle.During an interview with Resident #2 on 12/22/2025 at 9:35 AM he stated that he used the call light around 6:30 AM this morning and CNA B came in and stated she would be back. Resident # 2 stated that CNA B had not come back, and the soiled washcloth that he used to clean himself with needed to be removed from the bedside table. Resident # 2 stated that he had placed the soiled washcloth on the bedside table so CNA B could take it to the laundry room to be washed. Resident # 2 stated that the urinal was full and needed to be emptied. Resident # 2 stated that he had placed his urinal on the bedside table so it could be emptied by CNA B.During an interview with CNA B on 12/22/2025 at 3:17 PM stated that she was Resident # 2's CNA and she was responsible for removing the soiled washcloth from the bedside table. CNA B stated she answered the call light around 6:30 AM and told Resident # 2 that she would be back. CNA B stated she did not return right then, and she could not recall the time she returned to assist Resident #2. CNA B stated that she was assisting other residents call lights and she totally forgot to return to Resident # 2 to remove the soiled washcloth from the bedside table. CNA B stated it was expected for her to remove Resident # 2's soiled wash cloth he used to clean himself for infection control. CNA B stated that she was assisting other residents call lights and she totally forgot to return to Resident # 2 to empty the urinal. CNA B stated it was expected for her to empty Resident # 2's urinal to prevent from spilling.During an interview with the DON on 12/22/2025 at 4:35 PM, the DON stated it was expected for CNA B to remove the soiled washcloth after each use for infection control purposes. The DON stated it was expected for CNA B to empty Resident #2's urinal. The DON stated rounds were made every two hours and any staff can empty a urinal. The DON stated with the urinal filled it could be knocked off the bedside table and may cause a slip and fall. During an interview with the ADM on 12/22/2025 at 5:19 PM, the ADM stated it was expected for CNA B to have removed the soiled washcloth on the bedside table. It was expected for CNA B to bag the soiled washcloth to be sent to laundry to be washed. the ADM stated it was expected for CNA B to empty Resident # 2's urinal. The ADM stated that a slip and fall could have occurred if the urinal had been knocked over and spilled over on the floor. The ADM stated any staff can empty a urinal when it is full.Review of the facility policy Policies and Practices Infection Control revised 07/2014 reflected This Facility Infection Control policies and practices are intended to facilitate maintaining a safe, sanitary a safe, sanitary and comfortable environment and to help percent and manager transmission of diseases and infections.