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	04/17/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41654 Based on observations, interviews, and record review, the facility failed to ensure residents received services in the facility with reasonable accommodations of resident's needs and preferences except when to do so would endanger the health and safety of the resident or other residents for 2 of 6 residents (Resident #7 and #34) reviewed for resident rights. The facility failed to ensure Resident's #7's and Resident #34's call lights were within reach on 04/15/25. This failure could place residents at risk of needs not being met. Findings included: 1. Record Review of Resident #7's face sheet dated 04/16/25 reflected the resident was an [AGE] year-old female admitted on [DATE]. Her diagnoses included hypertensive heart disease with heart failure (when high blood pressure (hypertension) weakens the heart over time, leading to heart failure), diabetes (a group of diseases that result in too much sugar in the blood), Alzheimer's disease (a neurodegenerative disease that usually starts slowly and progressively worsens), and heart failure (a serious condition that occurs when the heart can't pump enough blood to meet the body's needs). Record Review of Resident #7's Annual MDS assessment dated [DATE] reflected Resident #7 was dependent on staff for eating, toileting, bathing, and personal hygiene. MDS reflected Resident #7 had a BIMS score of 06 which indicated Resident #7 was severely cognitively impaired. Record review of Resident #7's care plan dated 10/10/24 reflected: Resident at risk for falls due to weakness. Goal: Resident #7 would not sustain serious injury through the review date. Interventions included: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 04/15/25 at 10:38 AM, Resident #7 stated she was doing fine. She stated she could not reach her call light where it was at that time. She stated she usually could reach her call light. She stated the call light could have fallen on the floor but if she needed help, she would yell for someone to come in from the hallway. She stated she had no concerns. Observed Resident #7's call light on the floor beside resident's bed and out of resident's reach. The call light, from the other side of the room, which was intended for use by a roommate if resident had one, was placed in a drawer on the side of residents bed , and was also out of resident's reach. Resident demonstrated that she could not reach either of the call lights. In an observation on 04/15/25 at 11:00 AM, Resident #7's call light remained on the floor beside resident's bed, and the other call light remained in a drawer beside resident's bed and out of Resident #7's reach. 2. Review of Resident #34's quarterly MDS assessment dated [DATE], reflected a [AGE] year-old-female who was admitted to the facility on [DATE]. Her diagnoses included heart failure, high blood pressure, end stage renal disease (loss of kidney function), diabetes, high levels of fat stored in the body, morbid obesity, non-Alzheimer's dementia, anxiety (worry), depression (sadness), lupus (when the body's immune system mistakenly attacks its own tissues and organs), sleep apnea (interruptions in breathing during sleep), chronic pain syndrome, lymphedema (swelling caused by an accumulation of protein-rich fluid), and gout (buildup of uric acid crystals leading to severe pain commonly affecting the big toe). She was dependent on staff for almost all ADL's. She had a BIMS score of 07 indicating severe cognitive impairment. Review of Resident #34's care plan dated last revised 3/27/2025 reflected that she had a behavior problem r/t not using her call light and hollering out for help due to her cognition impairment. Her interventions included making sure her call light was within reach. Observation and interview on 04/15/2025 at 11:15 AM revealed Resident #34 was lying in bed. Her call light was resting on top of her oxygen concentrator approximately 2.5 feet from her bed. When asked, the resident stated she was unable to reach her call light if she needed it to call for help. During the interview, the resident began calling out to staff in pain related to her big toe and requested medication. CNA C entered Resident #34's room in response to the crying out. When asked, CNA C stated she was unaware of why the resident's call light was resting atop the oxygen concentrator and stated it should have been clipped to Resident #34's bed sheet. In an interview on 04/15/25 at 11:03 AM, CNA B stated Resident #7 could not reach her call light where it was at that time. CNA B stated she was going to fix the call light right then. She stated she knew how important it was for the residents to have their call lights and she was just trying to get everyone up and ready for the day. She stated the call light must have fell on the floor. She stated she had been trained on call light placement. She stated lots of things could happen and resident would not be able to call for help if their call light was out of the resident's reach. In an interview on 04/16/25 at 1:45 PM, the ADM stated it was his expectation that all residents' call lights be within reach at all times. He stated staff had been trained on call light placement and ensuring residents had their call light within reach at all times. He stated if a resident's call light was out of their reach, the resident would not have been able to call staff if they needed assistance or it could have caused a delay in care. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/16/25 at 3:24, the DON stated it was her expectation that all residents' call lights be within reach at all times. She stated staff had been trained on call light placement and ensuring residents had their call light within reach at all times. She stated if a residents call light was out of their reach, the resident may not have been able to call for help if they needed something. Interview on 04/17/2025 at 10:40 AM with CNA C revealed that she began working at the facility a couple of months ago and worked the 6am-2pm shift. She stated that Resident #34 could not get out of bed on her own. She stated that she believed that due to Resident #34's diagnosis, that she sometimes forgot how to use her call light and frequently yelled out for help from staff. She stated that the call light was supposed to always be in reach of the resident, but she was aware of times where the resident would throw the call light away from her body/bed. Record review of facility policy titled Answering the Call Light and dated 2001 (revised October 2010) reflected Purpose: The purpose of this procedure is to respond to the resident's requests and needs. General Guidelines: 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41654 Based on interview and record review, the facility failed to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity for 1 of 6 residents (Resident #45) reviewed for comprehensive assessments. The facility failed to complete an accurate comprehensive assessment for Resident #45 due to MDS assessment reflected resident received insulin and injections. This failure could place residents at risk of not having their care and treatment needs assessed to ensure necessary care and services were provided. The findings include: Record Review of Resident #45's face sheet dated 04/16/25 reflected the resident was a [AGE] year-old female admitted on [DATE]. Her diagnoses included acute respiratory failure with hypoxia (a serious condition where the lungs fail to adequately oxygenate the blood, leading to low blood oxygen levels), diabetes (a group of diseases that result in too much sugar in the blood), depression (feelings of severe despondency and dejection), and white matter disease - a progressive disorder that occurs when the white matter in the brain is damaged). Record Review of Resident 45's Annual MDS dated [DATE] reflected Resident #45 required set-up or clean-up assistance for eating, required supervision or touching assistance for toileting and bathing, and required partial or moderate assistance with personal hygiene. MDS reflected Resident #45 had a BIMS score of 13 which indicated Resident #45 was cognitively intact. Record review of Resident #45's Annual MDS assessment dated [DATE], reflected that resident was receiving injections and insulin. Record review of Resident #45's care plan dated 10/26/24 reflected: Resident had Diabetes Mellitus. Goal: Resident #45 would have no complications related to diabetes through the review date. Interventions included: Observe/document/report to MD PRN for s/sx of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing (hyperventilating), acetone breath (smells fruity), stupor, coma. Record review of Resident #45's undated Physician's Orders reflected resident had no orders for any type of injection or insulin medications ordered. In an interview on 04/16/25 at 1:06 PM, Resident #45 stated she did not receive insulin injections and she had not ever received insulin that she could remember. She stated she had been diagnosed with pre-diabetes but never required insulin. She stated she was doing well and was on her way to the resident council meeting. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/16/25 at 11:55 AM, LVN A stated she and another staff member were responsible for completing the MDS assessments in the facility. She stated she was trained on completing MDS assessments accurately. She stated she was not sure if Resident #45 received insulin or any injections then or when her last annual MDS was completed on 03/11/25, and she would have to look at the resident's records. She stated she was not sure if Resident #45's MDS dated [DATE] stated resident was receiving insulin or injections or not without looking at the MDS. She stated she had completed Resident #45's MDS dated [DATE]. She stated if a resident was not receiving insulin or any type of injections, it should not have reflected that they did on the MDS. She stated if an MDS assessment was completed inaccurately, it would not affect the resident in any way, but it would have caused the MDS assessment to fall under another RUG level. She stated the RUG score determined the amount of reimbursement the facility received for caring for the residents. In an interview on 04/16/25 at 1:45 PM, the ADM stated it was his expectation that MDS assessments were completed accurately and reflected the resident individually. He stated LVN A was responsible for completing the MDS assessments and she had been trained on completing the MDS assessments accurately as far as he knew. He stated if a resident had not received injections or insulin during the lookback period that the MDS required, the MDS assessment should not have reflected that a resident received insulin or injections he believed. He stated a RUG score was used to determine the amount of reimbursement the facility received for the care they provided to the resident. He stated if an MDS was completed inaccurately, it could have caused an error in billing. In an interview on 04/16/25 at 3:24, the DON stated it was her expectation that MDS assessments were completed to accurately reflect the resident individually. She stated LVN A was responsible for completing the MDS assessments, and LVN A had been trained on completing the MDS assessments accurately. She stated if a resident had not received injections or insulin during the period for coding on an MDS, the MDS assessment should not have reflected that a resident received insulin or injections. She stated a RUG score was used to determine the amount of reimbursement the facility received for the care they provided to the resident. She stated if an MDS was completed inaccurately, it could have caused an inaccurate payment to the facility, but it would not have affected the resident. Record review of the facility's policy titled Resident Assessment Instrument and dated 2001, revised on September 2010 reflected: Policy Statement - A comprehensive assessment of a resident's needs shall be made within fourteen (14) days of the resident's admission. Policy Interpretation and Implementation - 1. The Assessment Coordinator is responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessments and reviews according to the following schedule: a. Within fourteen (14) days of the resident's admission to the facility; b. When there has been a significant change in the resident's condition; c. At least quarterly; and d. Once every twelve (12) months. 2. The Interdisciplinary Assessment Team must use the MDS form currently mandated by Federal and State regulations to conduct the resident assessment. Other assessment forms may be used in addition to the MDS form. 3. The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity. 4. Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning.