

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: 675624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER Whitehall Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1116 E Loop 304 Crockett, TX 75835	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a resident who is unable to carry out activities of daily living receive the necessary services to maintain good personal hygiene for 1 of 12 residents (Resident #31) reviewed for ADLs. The facility failed to provide ADL care to Resident #31 from 2/14/2026 to 2/25/2026. This failure could cause all residents not to receive daily personal hygiene needs and cause the residents to have health, social, and emotional issues. Findings included: Record review of Resident 31's facility face sheet, dated 02/24/2026, indicated Resident #31 was an [AGE] year-old male, admitted [DATE], with diagnosis of dementia. Record review of Resident #31's quarterly MDS assessment, dated 12/29/2025, revealed a BIMS was not completed, and facility completed a SAMS that indicated Resident #31 had severely impaired cognition for decision making. He was dependent on staff for all ADLs. Record review of Resident #31's comprehensive care plan, revision date 7/31/2024, indicated Resident #31 had an ADL self-care performance deficit, was at risk for not having their needs met in a timely manner and to provide shower, shave, oral care, hair care, and nail care per schedule and when needed. Record review of a shower schedule, dated 2/24/2026, indicated Resident #31 was to receive a shower on Monday, Wednesday and Friday on the night shift. Record review of Resident #31's ADL response in his medical recorded, dated from 01/26/2026 to 02/24/2026, indicated Resident had not received a bath or shower since 02/14/2026. There was a response on 02/18/2026 and 02/24/2026 stating not applicable. This indicated he had missed 4 showers. Record review of Resident #31's skin observation worksheet, dated for January 2026 and February 2026, indicated Resident #31 had not had a skin observation worksheet completed since 02/13/2026. During an observation on 02/23/2026 at 10:59 am, Resident #31 had facial hair, a white substance built up on his lips and nails on both hands had a thick black substance under them. During an observation and interview on 02/24/2026 at 8:30 am, Resident #31 was lying in bed with his eyes closed. He had fascial hair, white buildup on his lips and under his nails on both hands had a thick black substance. He could not answer regarding when he last received a bath and said do what you got to do. During an observation on 02/25/2026 at 8:30 am, Resident #31 was up in a wheelchair at the nurses' station. He was awake and his fascial hair remained as well as the buildup on his lips and black substance under his nails. During an interview on 02/25/2026 at 8:35 am, CNA H said that the CNA's used the shower schedule at the nurse's station to know who was scheduled for what day and shift. She said Resident #31 was on night shift for showers. She said that when a shower was given, all care should include skin, nails, shave and mouth care. She said then the CNA completed a skin observation sheet and gave the skin sheet to the nurse. She said when a resident refused the nurse was notified. She said the CNA charted in the computer the shower was given or refused but never not applicable unless they were out of the facility. She said Resident #31 would sometimes hit at staff and say inappropriate things to staff but did not refuse care. She said dependent residents that did not get ADL care could have skin breakdown or infections. During an interview on 02/25/2026 at 8:41 am, LVN E said the charge nurses were responsible for oversight of the CNAs. She said the nurses should ensure that resident care was performed. She said the CNAs had a schedule to follow and could not speak to the night shift, but the (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	day CNAs turned in a skin observation sheet with each shower for her to review and if the resident refused it was charted in the medical record. She said ADLs for dependent residents should be completed to prevent infections and skin breakdown. During an interview on 02/25/2026 at 9:46 am, the DON said the CNAs were responsible for completing ADL care for all residents and the charge nurses were to oversee that the care was completed. She said the CNAs were to complete a skin observation sheet after a bath and record the bath in the resident record. She said she was not sure why not applicable would be checked. She said if a resident were to refuse the nurse was to be notified. She said dependent residents should have mouth care daily, baths as scheduled with shaving, skin and nail care. She said that failing to provide ADL care to residents could result in infections and skin breakdown. During an interview on 02/25/2026 at 1:16 pm, the Administrator said that the CNAs were responsible for the residents ADL care, and the nurses should be providing oversight that the care was completed. She said their process had been for the CNA to complete a skin observation sheet with each bath or shower, the nurse reviewed them, and she would see that that process was completed. She said she expected all residents to receive personal hygiene per the schedule to prevent skin breakdown and infections. Record review of a facility policy titled Clinical Practice Guideline Activities of Daily Living dated 1/23/2016 indicated, .Residents will receive essential services for activities of daily living to maintain good nutrition, grooming, and personal and oral hygiene, A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, personal and oral hygiene .		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents' environment remains as free of accident hazards as possible for 4 of 12 residents (Resident's #35, #17, #65, and #66) reviewed for quality of care. The facility failed to remove worn and damaged mechanical lift slings from service for Resident's #35, #17, #65, and #66. This failure could result in a loss of quality of life due to injuries. Findings included: 1. Record review of Resident # 35's face sheet, dated 2/24/2026, indicated Resident # 35 was a [AGE] year-old female, admitted [DATE], with diagnoses of cerebral infarction (stroke), hypertension (high or raised blood pressure) and peripheral vascular disease (decreased circulation in the lower extremities). Record review of Resident # 35's annual MDS assessment, dated 02/06/2026, indicated Resident #35 had a BIMS score of 15 indicating intact cognition, was dependent on staff for assistance with all ADLs, used a motorized wheelchair, and section GG indicated dependent for mobility and does not walk. Record review of Resident # 35's comprehensive care plan, revision date 02/16/2026, indicated Resident 35's care plan indicated transfers: partial and moderate assistance. The care plan did not reflect the current transfer status of requiring a mechanical lift. Record review on 02/24/2026 of Resident # 35's order summary report dated 02/24/2026 revealed Resident #35 indicated there was no order related to Resident # 35's transfer status or use of mechanical lift. During an observation and interview on 02/24/2026 at 11:00 am, Resident # 35 in bed in her room. Resident # 35 had a lift sling with straps faded in color, light pink for red, strap green or blue is white with light green stitching. Resident #35 said they use the mechanical lift everyday to transfer her to the wheelchair. 2. Record review of Resident #17's face sheet, dated 2/24/2026, indicated Resident #17 was an [AGE] year-old female, admitted [DATE], with diagnoses of Alzheimer's disease (a neurodegenerative disease that usually starts slowly and progressively worsens), chronic obstructive pulmonary disease (a condition that limits airflow into and out of the lungs), and hypertension (high blood pressure). Record review of Resident's 17's quarterly MDS assessment, dated 2/6/2026, indicated Resident #17 had a BIMS score of 00 indicating severe cognitive impairment, was dependent on staff for assistance with ADLs, used a wheelchair, and section GG indicated resident was dependent for transfers and mobility. Record review of Resident # 17's comprehensive care plan, revision date 08/22/2025, Resident 17's care plan indicated transfers: dependent. Record review on 02/24/2026 of Resident # 17's order summary report dated 02/24/2026, revealed there was no order related to Resident # 17's transfer status or use of mechanical lift. During an observation on 02/24/2026 at 1:00 pm, Resident # 17 was sitting in a wheelchair in the lobby watching television. Resident # 17 had a lift sling located under her with straps faded in color, light pink for red, strap green or blue is white with light green stitching. Unable to interview Resident # 17 due to severe cognitive impairment. 3. Record review of Resident #65's face sheet, dated 2/24/2026, indicated Resident #65 was an [AGE] year-old male, admitted [DATE], with diagnosis of displaced intertrochanteric fracture of the left femur (broken bone of upper left leg). Record review of Resident's 65's admission MDS assessment, dated 2/19/2026, indicated Resident #65 had a BIMS score of 15 indicating he was cognitively intact, he required assistance of 1 for transfers. Record review of Resident # 65's comprehensive care plan, revision date 02/23/2026, indicated Resident 65's care plan indicated transfers: maximum assist of 1 person. Record review on 02/24/2026 of Resident # 65's order summary report dated 02/24/2026, revealed there was no order related to Resident # 65's transfer status. During an observation on 02/23/2026 at 9:30 am and 3:00 PM, and on 02/24/2026 at 8:30 AM, Resident # 65 had a wheelchair in his room with a mechanical lift sling located in the chair. The lift sling located in the wheelchair had straps faded in color, light pink for red, strap green or blue is white with light green stitching. The labels on the lift sling were faded and the print on the label was faded and illegible. During an interview with Resident # 65 on (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/24/2026 at 8:30 AM he stated that he stands and transfers with the assistance of staff. He denies ever transferring with the assistance of a mechanical lift. He stated he believed that the lift sling was a chair cover and was not aware that it was used for transfers. He stated he has been transferred from his bed to his chair with the assistance of 1 CNA since he was admitted from the hospital.4. Record review of Resident #66's face sheet, dated 2/24/2026, indicated Resident #66 was an [AGE] year-old female, admitted [DATE], with diagnoses of unspecified dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and senile degeneration of the brain (the gradual deterioration of brain cells and their connections, leading to a progressive loss of cognitive and motor functions).Record review of Resident's 66's quarterly MDS assessment, dated 01/31/2026, indicated Resident #66 had a BIMS score of 07 indicating severe cognitive impairment, used a wheelchair, and section GG indicated resident was dependent for transfers and mobility.Record review of Resident # 66's comprehensive care plan, revision date 03/27/2024, indicated Resident 66's care plan indicated transfers: dependent. The care plan did reflect the current transfer status of requiring a mechanical lift.Record review on 02/24/2026 of Resident # 66's order summary report dated 02/24/2026, revealed there was no order related to Resident # 66's transfer status or use of mechanical lift.During an observation on 02/24/2026 at 1:00 pm, Resident # 66 was sitting in a wheelchair in the lobby watching television. Resident # 66 had a lift sling located under her with straps faded in color, light pink for red, strap green or blue is white with light green stitching and the print on the label was faded and illegible.Unable to interview Resident # 66 due to severe cognitive impairment.During an interview on 2/24/2026 at 8:15 am CNA A she said she had training on mechanical lift transfers and watching for fading, rips and tears, threads coming unsewn on the slings used for transfers. CNA A said faded slings should be removed from service. CNA A said using a mechanical lift sling that was faded could cause injury if the straps broke.During an interview on 2/24/2026 at 8:50 AM with CNA B, she stated that Resident #65 was a one person assist with transfers. She stated that the resident was able to stand and pivot to chair and that a mechanical lift was not used on the resident. She stated that a mechanical lift has not ever been used on Resident #65. When asked about the lift sling that was in the wheelchair of Resident #65 she stated she was not sure why the item was in his room. She said that any lift slings for resident use should be free of wear and tear, no holes or fraying and that there should not be any faded material. She stated the sling located in Resident #65 room should be taken out of service and not available for use. She stated staff could take the lift sling to another resident's room for use and it would be a risk for injury to the resident if the sling was in poor condition. She stated any torn or faded slings should be disposed of and not available to staff for use. During an interview on 2/24/2026 at 9:00 AM with CNA C, she stated that Resident #65 was a one person assist with transfers. She stated a mechanical lift was not used on Resident #65. When asked about the lift sling that was in the wheelchair of Resident #65 she stated she was not sure why the item was in his room or who placed it in there. She said that any lift slings for resident use should be free of wear and tear, no holes or fraying and that there should not be any faded material. She stated the sling located in Resident #65 room should not be available for use. She stated staff could take the lift sling to another resident's room for use and it would be a risk for injury to the resident if the sling was in poor condition. She stated any torn or faded slings should be disposed of and not available to staff for use.During an interview on 2/24/2026 at 1:30 PM, LVN J said that slings should be monitored for any holes or tears. When asked about fading of the loops or fabric she stated she was not aware that faded loops would be a reason to take lift slings out of service. She said that a damaged lift sling could lead to injury to a resident during transfer. During an interview on 02/25/2026 at 9:00 AM, the DON said the staff are in-serviced on signs of wear and tear and to remove mechanical lift slings from service if they have rips, tears and coming unsewn. She said the lift slings used for Residents #17, # 35, #65 and #66 were removed from service due to their fading and new lift slings were distributed. She said that using the faded lift sling could cause injury if it broke. DON said that they had obtained physician orders on all the residents (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	needing a mechanical lift to transfer and had updated all care plans to include interventions for correct transfer status including mechanical lifts if applicable. During an interview on 02/25/2026 at 9:15 AM, the Administrator said the lift sling used for Resident's #17, #35, #65 and #66 were removed from service. She said they would have an in-service with staff. She said that using the faded lift sling could cause injury if it broke. During an interview on 02/25/2026 at 9:30 AM, the Laundry Aide said she washes the mechanical lift slings without bleach and she hangs them to air dry. Record Review of Facility policy dated 09/13/2024 Hydraulic Lift (Hoyer Lift) .Policy: To enable one individual to lift and move a resident safely, with as little effort as possible. Procedure. Record Review of Manufacturer's recommendations accessed www.medline.com 02/11/2026 Indicated: Always inspect slings prior to each use Signs of rips. tears. or frays indicate sling wear which is unsafe and could result in injury Signs of fading. bleached areas. or permanent wrinkles on the straps indicate improper laundering which is unsafe and could result in injury Any slings with signs of wear or improper laundering should be immediately removed from use. Always confirm compatibility between the connection style of the patient sling and the patient lift before use. Do not remove sling labels. If sling labels are removed or no longer legible. sling must be immediately removed from use. Frequency of laundering should follow facility guidelines, or when the sling is soiled. Refer to the sling's tag for laundering instructions and follow all wash instructions.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, 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 2 of 5 residents (Resident #1 and Resident #53) and 3 of 7 staff (CNA A, CNA D and CNA G) reviewed for infection control. 1. The facility failed to ensure CNA D changed her gloves and did not touch clean items with dirty gloves when incontinent care was provided to Resident #1 on 02/24/2026. 2. The facility failed to ensure CNA A and CNA G followed EBP when completing direct resident care and CNA G changed her gloves and performed hand hygiene when incontinent care was given to Resident #53 on 02/23/2026. 3. The facility failed to ensure CNA G transported soiled linens and completed hand hygiene to prevent the spread of infections on 02/24/2026. These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices. Findings included: 1. Record review of an admission Record for Resident #1 dated 2/25/2026 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of critical illness myopathy (muscle weakness from prolonged immobilization), pressure ulcer of sacral region (bed sore on the tailbone), and depression. Record review of an admission MDS Assessment for Resident #1 dated 2/9/2026 indicated she did not have any impairment in thinking with a BIMS score of 15. She was dependent on staff for toileting hygiene. She was always incontinent of urine/bowel. Record review of a care plan for Resident #1 dated 2/3/2026 indicated she was incontinent of bowel/bladder related to critical illness myopathy. Interventions included to check frequently for wetness and soiling and change as needed. During an observation on 2/24/2026 at 3:15 pm, CNA D was in the room of Resident #1 to perform incontinent care. CNA D donned (put on) a gown and gloves but did not perform hand hygiene prior to applying gloves. She removed the resident's pants because they were wet and opened the brief and pulled it down between her thighs. She removed wipes from the package and wiped both inner thighs and down the middle of her vagina from front to back and placed the wipes in the trash. The resident was rolled onto her right side and CNA D removed wipes from the package and wiped her rectal area from front to back and placed the wipes in the trash. She removed the brief and rolled it into a ball and left it sitting on the bed. She did not remove her gloves after touching the dirty brief. She placed a clean brief under the resident's buttocks and secured it. She put clean pants on the resident, touched the bed control and lowered the bed. She placed the brief in the trash bag and doffed (removed) her gown and gloves. She went into the bathroom and washed her hands. She exited the room and placed the bag of trash in the bin in the hallway. She entered another room on hall 100 and left the package of wipes in the room and exited. During an interview on 2/24/2026 at 3:25 pm, CNA D said she had been employed at the facility for 2 years and worked 6 am -6 pm on hall 100 where Resident #1 resided. When questioned about the incontinent care provided to Resident #1, she said she would not have done anything differently. When she was questioned about the use of gloves, she said she would only change gloves if they were contaminated, visibly dirty or if she had to pick something up from the floor. She said she forgot to wash or sanitize her hands before care was started and did not change her gloves and should have changed them before she placed a clean brief on the resident. She said it had been a long time since she had a skills check off. She said they did not have enough packages of wipes to leave wipes in every resident room but thought that placing wipes in bag before going into the resident's room would make sense. She said there was a risk of cross contamination and infection if they touched clean items with dirty gloves or did not change gloves when care was provided. Record review of a long-term care CNA skills/competency checklist for CNA D dated 6/30/2025 by the DON indicated she met the requirements for perineal care for a female resident and hand hygiene with infection control. Record review of an individual employee in-service record for CNA D dated 12/1/2025 indicated the ADON provided a verbal review of training (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on infection control with the use of gloves. 2. Record review of Resident #53's facility face sheet, dated 2/24/2026, indicated Resident #53 was an [AGE] year-old female, admitted [DATE], with diagnosis of dementia. Record review of Resident #53's significant change MDS assessment, dated 01/26/2026, revealed a BIMS was not completed, and facility completed a SAMS that indicated Resident #53 had severely impaired cognition for decision making. She was dependent on staff for all ADLs, required a feeding tube and was always incontinent of bowel and bladder. Record review of Resident #53's comprehensive care plan, revision date 10/13/2025, indicated Resident #53 required the use of a feeding tube but did not address EBP requirement related to feeding tube. She was incontinent of bowel and bladder and to monitor for signs of urinary tract infections. Record review of Resident #53's order summary report, dated 2/24/2026, indicated Resident #53 had an order dated 6/09/2025 for EBP related to her feeding tube. During an observation on 02/23/2026 at 3:05 pm, Resident #53 had an EBP sign posted outside her door indicating a gown and gloves were required for care. During an observation on 02/23/2026 at 3:11 pm, CNA A and CNA G enter Resident #53's room to perform incontinent care. Neither CNA A nor CNA G applied a gown per the EBP standard prior to performing care. Both CNAs adjusted the linen and resident's gown. CNA G opened Resident #53's brief and cleaned her with wipes from front to back. CNA A rolled Resident #53 to her left side and CNA G cleaned the back area with wipes and removed her soiled brief and placed it in a bag. She then proceeded to apply a new brief and skin barrier without changing her soiled gloves. Both CNAs then adjusted the resident's linens. CNA G removed her soiled glove from her left hand and adjusted the bed position using the bed remote control. Both CNAs removed their soiled gloves and placed them in a bag. CNA A sanitized her hands and left Resident #53's room, however CNA G left Resident #53's room without hand hygiene. CNA G then placed a pack of wipes from Resident #53's room back on the clean linen cart, the soiled bag in the trash receptacle and never performed hand hygiene. During an interview on 02/23/2026 at 3:16 pm, CNA A said Resident #53 had a feeding tube and she should have applied a gown before performing care. She said the PPE was to protect the residents from transmission of germs. She said she had been properly trained and just forgot to pay attention. During an interview on 02/23/2026 at 3:17 pm, CNA G said that she should have applied a gown before performing care for Resident #53 but was nervous. She said she should have removed her soiled gloves, performed hand hygiene and put on new gloves before proceeding after removing Resident #53's soiled brief. She said she should have performed hand hygiene before leaving the resident's room. She said should have removed needed wipes from the package, not brought the package in the room and put the package back on the clean linen cart. She said all these failures could cause the spread of infections and she had been trained on infection control measures. 3. During an observation on 02/24/2026 at 2:28 pm, CNA G exited from room [ROOM NUMBER] with unbagged soiled linen in her gloved hands. She walked down the hallway approximately 20 feet and placed the soiled linen in the soiled linen receptacle and then removed her gloves and placed them in the trash. She returned to room [ROOM NUMBER] and washed her hands. During an interview on 02/24/2026 at 2:35 pm, CNA G said she knew not to bring unbagged soiled linen in the hall and wear soiled gloves, but she was in a hurry. She said she should place all soiled linen in a bag, remove her gloves and perform hand hygiene before leaving any resident room. She said by not following infection control measures she could spread germs in the facility. During an interview on 02/24/2026 at 3:50 pm, the DON said that she and other nurse managers were responsible for training staff on the infection control program. She said she was also the Infection Preventionist for the facility. She said regarding the CNAs taking the wipe packages in the resident's room that was something the nurse aides had been doing but they should have only been taking the wipes needed for the care and place them in a plastic bag. She said the CNAs should always perform hand hygiene before care, before applying gloves, after gloves changes, and before leaving the resident's room. She said gloves should be changed during incontinent care when going from soiled to clean. She said soiled linens should be bagged for transport. She said residents with EBP staff should have a gown and gloves for care and the sign on the door was their (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	aid for staff to know when EBP was required. She said that staff not following the infection control program could spread infections and she would begin retraining. During an interview on 02/25/2026 at 1:16 pm, the Administrator said the DON and ADON were responsible for ensuring all staff were following the infection control program. She said that infection control should be always followed by all staff. She said if the resident was on EBP, EBP should be followed. Hand hygiene should occur before entering resident rooms, before leaving a resident room and any other required time. She said linens should always be bagged and not carried freely in the hallway. She said not following the infection control program could lead to the spread of infections. Record review of a facility policy titled Infection Prevention and Control Program dated 11/2024 indicated, .This facility has established and maintains 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 as per accepted national standards and guidelines.6. Enhanced Barrier Precautions EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.EBP are indicated for residents with any of the following: a. Infection or colonization with an MDRO when Contact Precautions do not otherwise applyb. Wounds and/or indwelling medical devices (e.g., central lines, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status During high-contact resident care activities:12. e. Soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. Soiled linen shall not be kept in the resident's room or bathroom . Record review of a facility policy titled Hand Hygiene revised 2/11/2022 indicated, .All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. 6 a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves .		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER Whitehall Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1116 E Loop 304 Crockett, TX 75835	
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 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** Based on observations, interviews, and record review, the facility failed ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 of 6 residents (Resident #53) reviewed for accommodation of needs. The facility failed to ensure Resident #53's call light in the room was left within reach when she was in bed on 02/23/2026 and 02/24/2026. This failure could place residents at risk of injury, pain, hospitalization, and a diminished quality of life. Findings: Record review of Resident 53's facility face sheet, dated 02/24/2026, indicated Resident #53 was an [AGE] year-old female, admitted [DATE], with diagnosis of dementia. Record review of Resident #53's significant change MDS assessment, dated 01/26/2026, revealed a BIMS was not completed, and facility completed a SAMS that indicated Resident #53 had severely impaired cognition for decision making. She was dependent on staff for all ADLs. Record review of Resident #53's comprehensive care plan, revision date 10/13/2025, indicated Resident #53's had a potential for falls and to place call light in reach to use for assistance. During an observation on 02/23/2026 at 11:06 am, Resident #53 was lying in bed, and her call light was attached to itself at the wall out of reach. During an observation on 02/23/2026 at 3:53 pm, Resident #53 was lying in bed and her call light remained attached to itself at the wall out of reach. Resident #53 was unable to communicate or answer questions regarding call light. During an observation on 02/24/2026 at 11:05 am, Resident #53 was lying in bed and her call light was on the wall plug out of reach. Resident #53 had trouble communicating but was able to demonstrate pushing the call light when it was handed to her. During an interview on 02/24/2026 at 11:10 am, CNA A said that Resident #53 could use her call light but never did. She said they kept her door open so they could visibly see her when making rounds and checked her every 2 hours to ensure she was good. She said all residents should have access to their call lights and could have negative outcomes if they couldn't call for help. During an interview on 02/25/2026 at 8:40 am LVN E said that all staff should ensure each resident could reach their call light so they could call for help if they need to. She said Resident #53 did not use her call light that she was aware of but should still have it near in case she wanted to use the light. She said a call light out of reach could result in resident injuries. During an interview on 02/25/2026 at 9:46 am, the DON said that all staff should ensure resident call lights were in reach. She said each time rounds were made the call light should be placed back in reach for the residents to use if they desired before leaving the room. She said the staff were trained verbally on call light placement on hire and annually. She said she expected each resident to have access to their call light to prevent injuries. During an interview on 02/25/2026 at 1:16 pm, the Administrator said that residents call lights should always be within reach and was the responsibility of everyone that rounds. She said all staff were trained on call light placement on hire, annually and as needed and discussed through resident rights. She said if call lights were not in place resident injuries could occur. Record review of a facility policy titled Call Light Response, dated 8/11/13, indicated, Place call light/bell within patient's reach regardless of patient location such as: in bed, on commode, unaccompanied in sitting area .		

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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 observation, interview, and record review the facility failed to ensure comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 2 of 12 residents (Residents #35 and #53) reviewed for comprehensive care plans. 1. The facility failed to ensure Resident #35's comprehensive care plan was revised to reflect current transfer status of requiring a mechanical lift. 2. The facility failed to ensure Resident #53's comprehensive care plan was revised to reflect requiring EBP related to feeding tube. These failures could place residents at increased risk of falls, injuries, delay in care and/or a decreased quality of life. Findings included: 1. Record review of Resident # 35's face sheet, dated 2/24/2026, indicated Resident # 35 was a [AGE] year-old female, admitted [DATE], with diagnoses of cerebral infarction (stroke), hypertension (high or raised blood pressure) and peripheral vascular disease (decreased circulation in the lower extremities). Record review of Resident # 35's annual MDS assessment, dated 02/06/2026, indicated Resident #35 had a BIMS score of 15 indicating intact cognition, was dependent on staff for assistance with all ADLs, used a motorized wheelchair, and section GG indicated dependent for mobility and does not walk. Record review of Resident # 35's comprehensive care plan, revision date 02/16/2026, indicated Resident 35's care plan indicated transfers: partial and moderate assistance. The care plan did not reflect the current transfer status of requiring a mechanical lift. Record review on 02/24/2026 of Resident # 35's order summary report dated 02/24/2026 revealed Resident #35 indicated there was no order related to Resident # 35's transfer status or use of mechanical lift. During an interview and observation on 02/24/2026 at 12:16 pm of a Kardex (electronic plan of care) for Resident #35, CNA A said the Kardex had no interventions listed for transfers using a mechanical lift. CNA A said that when Resident #35 came back from the hospital she was unable to stand for transfers and the staff started using a mechanical lift for her transfers. She said a new staff member would not be aware of the correct transfer status if the Kardex was not correct. CNA A said using the incorrect transfer could result in injuries. During an interview on 02/24/2026 at 4:20 pm the Regional Reimbursement Consultant said the facility has had turnover in the MDS and care plan position and she does her best to oversee the care plans are correct and included the required elements per policy. She said the facility has put a new employee in that position as of last week and she will be training her. She said that the transfer status was missed when Resident #35 reentered the facility in May of 2025 after hospitalization and she had corrected it to reflect two-person transfer with mechanical lift today. She said not having the correct status on the care plan could cause injuries if the incorrect transfer procedure for the residents was not followed. During an interview on 02/24/2026 at 9:15 AM, the DON said not having the correct transfer status on the care plan could cause injury if the staff were not aware of what was required for safety. The DON said the care plan was updated yesterday and orders obtained for use of the mechanical lift for transfers for Resident #35. During an interview on 02/24/2026 at 9:30 AM, the Administrator said the care plan interdisciplinary team was responsible for making changes in the resident's care and updating the care plans. She said not having the correct transfer status on the care plan could possibly cause injury to a resident if the staff was not aware of what transfer status was required. 2. Record review of Resident 53's facility face sheet, dated 2/24/2026, indicated Resident #53 was an [AGE] year-old female, admitted [DATE], with diagnosis of dementia. Record review of Resident #53's significant change MDS assessment, dated 01/26/2026, revealed a BIMS was not completed, and facility completed a SAMS that indicated Resident #53 had severely impaired cognition for decision making. She required a feeding tube. Record review of Resident #53's comprehensive care plan, revision date 10/13/2025, indicated Resident #53 had required the use of a feeding tube but did not address EBP requirement related to feeding tube. Record review of Resident (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#53's readmission progress note, dated 6/06/2025, indicated Resident #53 returned to the facility from the hospital with a feeding tube. Record review of Resident #53's order summary report, dated 02/24/2026, indicated Resident #53 had an order dated 6/09/2025 for EBP related to her feeding tube. During an observation on 02/23/2026 at 11:06 am, Resident #53 had an EBP sign outside her door and had a feeding tube with continuous feeding in place. During an interview on 02/24/2026 at 4:00 pm LVN F said that Resident #53 had a feeding tube since last year and had EBP in place. She said the MDS nurse completed the care plans, and she did not have a part in the revision or review of care plans. She said that the nurses did use the care plan at times but mainly followed the orders. She said incomplete care plans could cause a delay in care or inaccurate care. During an interview on 02/24/2026 at 4:20 pm, the Regional Reimbursement Consultant said that she was responsible for the MDS assessment oversight at the facility. She said the facility had not had a consistent MDS nurse for several months and she did not micromanage the department. She said she came to the facility 1-2 times a week but completed most of her work offsite. She said that she had been reviewing and revising care plans as they came due but had not completed them all. She said that Resident #53 should have had a care plan to reflect her feeding tube and need for EBP. She said the care plan should have been reviewed and revised with her comprehensive care plans and somehow it was missed. She said inaccurate care plans could result in residents not receiving care. During an interview on 02/25/2026 at 9:46 am, the DON said that the interdisciplinary team met to discuss resident care on admission, quarterly and with significant changes. She said during those meetings the team completed the team meeting note and the MDS nurse was responsible for reviewing and revising the care plan accordingly. She said the corporate MDS nurse that had been covering was not participating in the meetings and could not speak to why. She said inaccurate care plans could result in resident care delays and injuries. During an interview on 02/25/2026 at 1:16 pm, the Administrator said that the MDS nurse was responsible for reviewing and revising the resident's care plan. She said they had a lot of turnover with the MDS nurse position and the regional reimbursement consultant had been helping. She said the comprehensive care plan should be revised quarterly and as needed and should reflect all care the residents required. She said she expected the care plans to be revised per the regulations to prevent resident care issues. Record review of a facility policy titled Comprehensive Care Plans dated 9/04/2024 indicated, Comprehensive Care Plans Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 3. The comprehensive care plan will describe, at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 5. the comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment .		

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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 the drug regimen review recommendations from the pharmacy consultant were acted upon for 1 of 4 residents reviewed for drug regimen review. (Residents #34)The facility did not follow up on the pharmacy consultant's recommendations dated 1/24/2025 to 2/12/2026 with the physician for Resident #34. These failures could place residents at risk for medication errors, unnecessary medications, and incorrect administration. Findings included: Record review of an admission Record dated 2/24/2026 for Resident #34 indicated he admitted to the facility 10/7/2024 and was [AGE] years old with diagnoses of cerebral infarction (stroke), dementia with anxiety, peripheral vascular disease (impaired circulation to the legs) and atrial fibrillation (irregular heartbeat). Record review of active physician orders dated 2/24/2026 for Resident #34 indicated an order for Seroquel 25 mg give 12.5 mg by mouth one time a day for dementia with behaviors with a start date of 1/9/2025. An order for Seroquel 50 mg give one tabled by mouth every morning and at bedtime for behaviors and anxiety with a start date of 3/14/2025. An order for trazodone 50 mg give one tablet by mouth at bedtime for sleep insomnia with a start date of 1/22/2026. Record review of pharmacy recommendations of 2/12/2026 indicated Seroquel 50 mg every morning needed a CMS approved diagnosis to be continued. Record review of a Quarterly MDS Assessment for Resident #34 dated 12/20/2025 indicated he had severe impairment in thinking with a BIMS score of 0. There were not any behaviors noted during the look back period. He did not have any psychiatric/mood disorders. During the 7 day look back period he received antipsychotic medications. Drug regimen review did not indicate physician contact for prescribed/recommended actions. Record review of a care plan for Resident #34 revised 6/3/2025 indicated he required psychotropic drug use related to dementia with targeted/disruptive behaviors. Interventions included for medication regimen to be routinely reviewed by the pharmacist with all recommendations, including suggested reductions, to be forwarded on to the physician. Record review of pharmacy recommendation dated 2/20/2025 for Resident #34 indicated Seroquel needed a CMS approved diagnosis to be continued. Record review of pharmacy recommendations of 1/24/2025 indicated Seroquel needed a CMS approved diagnosis to be continued. During an interview on 2/25/2026 at 10:39 am, the DON said she along with the ADON were responsible for completing the pharmacy recommendations. She said the pharmacy consultant visited the facility monthly. She said the day after the consultant's visit they would review the pharmacy recommendations. She said Resident #34 was admitted to the facility with an order for Seroquel. She said the NP was contacted last week about a reduction in Resident #34's Seroquel and the NP told her the resident needed to be referred to psychiatric services. She said she asked the NP if the resident could have something else ordered due to him sleeping all day. She said she also talked to the Pharmacy Consultant as well to see if there was something else, they could try. She said she failed to review his recommendations from the Pharmacy Consultant and did not get an appropriate diagnosis for the use of Seroquel. She said she had been overwhelmed and it was missed. She said there was a safety risk if they did not review the pharmacy recommendations and ensure appropriate measures were put in place to protect the residents. During a phone interview on 2/25/2026 at 10:52 am, the NP said she had been going to the facility weekly for about 4-5 weeks. She said she had been contacted about Resident #34 with the biggest issue with him being up all night and sleeping all day. She said the MD was his physician and he wanted Resident #34 to refer to psychiatric services. She said she recently added trazadone to be given at night to help with his sleeping. She said Seroquel would be better managed by psychiatric services. She said she believed behaviors were an appropriate diagnosis for the use of Seroquel but did not prescribe antipsychotics. She said his physician did not allow her to prescribe antipsychotics. During a phone interview on 2/25/2026 at 11:01 am, the MD said Resident #34 was on Seroquel and it was prescribed to try and regulate his behaviors, outbursts, (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and agitation. He said the resident had dementia and worsening agitation. He said he did not recall if the facility sent him a recommendation from the Pharmacy Consultant requesting an appropriate diagnosis for the use of Seroquel. He said he was going to the facility that day to address a possible GDR for Seroquel. He said the facility was very diligent with contacting him. He said the Seroquel diagnosis was appropriate and they could use it. During a phone interview on 2/25/2026 at 11:11 am, the Pharmacy Consultant said she had been going to the facility since August 2024 and visited monthly. She said her last visit was 2/10/2026 and she reviewed Resident #34's medications. She said the use of psychotropic medications must have an appropriate diagnosis with the use of Seroquel and dementia was not an appropriate diagnosis for its use according to CMS regulations. She said she had been reminding the facility monthly since January 2025 that an appropriate diagnosis was needed. She said the facility had not responded to her in person and would tell her they were working on it. She said the purpose of the Pharmacy Consultant was to make sure things were in order and help the facility get in compliance. She said she had sent the MD messages before requesting a new diagnosis with no response. She said the last time she contacted him was in August 2025 and he told her he reminded the nurses to complete it but did not change the diagnosis. During an interview on 2/25/2026 at 11:25 am, the ADON said she had been employed at the facility since [DATE]. She said she was still in training. She said she would be responsible for helping the DON with pharmacy recommendations. She said she was not aware Resident #34 did not have an appropriate dx for the use of Seroquel. She said the resident had behaviors and was not sure if he was on psych services. She said the pharmacy consultant helped to keep the facility in compliance with state regulations and making sure the appropriate diagnosis were being used. She said consent for psychotropic medications should be completed before the initial dose was given to the resident, either written or verbal. She said there was a risk of not knowing what medications would be given and they should be made aware of the side effects of the medications. She said she did not see the pharmacy recommendation for Resident #34 that indicated he needed an appropriate diagnosis for the use of Seroquel after the pharmacy consultant visited the facility last week. During an interview on 2/25/2026 at 1:20 pm, the Administrator said the Pharmacy Consultant visited the facility monthly which included reviewing medications, and they would give recommendations. She said the DON was responsible for ensuring the recommendations were completed and sent them to the physicians usually in a day or two after the consultant's visit. She said she was not aware that Resident #34 did not have an appropriate diagnosis for the use of Seroquel and the Pharmacy Consultant had been telling the facility for over a year that one was needed for its continued use. She said going forward she would be involved in ensuring the pharmacy recommendations were completed. She said there could be a negative impact for the residents if they were not done. Record review of a facility policy titled Drug Regimen Review Process revised 10/3/2018 indicated, .It is the policy of this facility to conduct a drug regimen review upon a resident's SNF Prospective Payment System (PPS) admission and as indicated throughout the resident's stay. Medication irregularities identified and reported by the consultant pharmacist are maintained in an orderly, organized manner to track physician or nursing response. Monthly Drug Regimen Review: The Consultant pharmacist reviews the medication of each resident at least monthly and more frequently if deemed necessary. Recommendations that require Physician response are sent to Physician timely for follow up or the Physician is contacted by phone as indicated. The DON will validate that all recommendations sent to Physician, once returned are acted upon timely .		

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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 observation, interview, and record review the facility failed to, in accordance with accepted professional standards and practices, maintain medical records on each resident that were complete and accurately documented for 1 of 4 residents (Residents #34) reviewed for medical records. The facility failed to ensure Resident #34's medical records were accurate when LVN J documented meal intake for breakfast and lunch on 2/23/2026. This deficient practice could place residents at risk of improper care and monitoring due to inaccurate medical records. Findings include: Record review of an admission Record dated 3/24/2026 for Resident #34 indicated he admitted to the facility 10/7/2024 and was [AGE] years old with diagnoses of cerebral infarction (stroke), dementia with anxiety (restlessness, worry, agitation with a decline in thinking), PVD (decreased blood flow to the lower legs) and atrial fibrillation (irregular heartbeat). Record review of a MAR for Resident #34 dated 2/24/2026 indicated an order for the nurse to monitor his meals, document amount consumed and if less than 50% document substitute given with a start date of 1/19/2026. Record review of a MAR for Resident #34 dated 2/23/2026, LVN J documented he ate 100% at breakfast and 75 % at lunch. Record review of a meal intake sheet dated 2/23/2026 indicated Resident #34 did not have any documentation for breakfast, lunch, or dinner for his meal intake. Record review of a care plan for Resident #34 revised 1/15/2026 indicated he received a mechanical soft diet and was at risk for malnutrition/dehydration with unintended weight loss. Interventions included helping the resident to form a wake and sleep cycle to allow him to be up for meals as appropriate. Record review of a Quarterly MDS Assessment for Resident #34 dated 12/20/2025 indicated he had severe impairment in cognition with a BIMS score of 0. There were not any behaviors noted during the look back period. He required substantial/maximal assistance with eating. During an observation on 2/23/2026 at 2:15 pm, Resident #34 was in bed resting with his eyes closed and his lunch tray sitting on the over bed table that had been untouched. During an observation and interview on 2/23/2026 at 2:40 pm, CNA D was in the room of Resident #34 to provide incontinent care. She said he would sleep all day until about 3 pm. She asked him if he was hungry and he said he was and his lunch tray was still sitting on the over bed table. She said he slept most of the day and was up at night. During an observation and interview on 2/23/2026 at 3:32 pm, Resident #34 was asleep in bed. His lunch tray was still untouched on his overbed table. CNA D said he had not eaten anything today, breakfast nor lunch. During an observation and interview on 2/24/2026 at 2:02 pm, Resident #34 was sitting up in a wheelchair looking out the window in the hallway leading to the kitchen. He was alert to person only with confusion noted. CNA D was present and said he had been up since around 12 pm and he ate 100% of his lunch. During an interview on 2/24/2026 at 2:12 pm, LVN J said she had been employed at the facility for a year and worked 6 am -6 pm shift. She said the nurses were responsible for monitoring and documenting the meal intake of Resident #34 daily. She said when he was fully awake, he would eat about 100% of his meals, but when he was not fully awake, he would holler out, and it would be hard for him to focus on eating his meals. She said that day at breakfast, he had a supplement shake and lunch he ate 100%. She said she could not remember his intake for breakfast and lunch yesterday 2/23/2026, so she looked at her documentation and said she charted he ate 100% at breakfast and lunch 75%. She said at lunch yesterday she gave him cookies and a health shake. She could not remember anything about his breakfast intake. When asked about his lunch tray that sat in his room for hours yesterday, she said she did not offer him the lunch meal because it was cold. She said there was a sheet at the nurse station where the staff would document the percentage of each resident's meal intake. She said the sheet for 2/23/2026 did not have any documentation on it for Resident #34. She said she did not follow up after meals to ensure the documentation was correct for each resident with the percentage of meals eaten. She said the documentation for his meal intake yesterday (2/23/2026) was incorrect (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and false documentation. She said there could be a risk for weight loss if the information was not accurate for a resident who was on weekly weight monitoring. She said he had a lot of behaviors and had periods of time when he did not want to eat so he was placed on weekly weights. During an interview on 2/25/2026 at 11:25 am, the ADON said she had been employed at the facility since February 10, 2026. She was responsible for monitoring the POC documentation in the resident records that included documentation of meal intakes. She said she had an in-service with the staff on documenting meal intakes and the nurse aides were responsible for the documentation. She said if a resident did not eat, staff should let the charge nurse know so interventions could be put in place. If documentation were not correct, they should complete an addendum and if not then it could lead someone to believe the information was correct. During an interview on 2/25/2026 at 1:20 pm, the Administrator said meal intakes should be recorded by the charge nurses daily. She said Resident #34 liked to snack and stayed up at night. She said she was made aware of the documentation that LVN J made on Resident #34. She said staff should have better documentation and it varied with the intake Resident #34 received. She said at night they would give him snacks if he was up. She said if the documentation was entered into the system in error, the staff should create an addendum to correct the incorrect information. She said if the information were not corrected, it would be inaccurate and could impact care. She said they started conducting in-services with the staff and have changed their system for a better recording of meal intakes for the residents. Record review of an in-service training report dated 2/25/2026 by the Administrator titled meal service and documentation of intake was conducted. Record review of a facility policy titled Clinical Document Guidelines revised 3/25/2025 indicated, .The patient's clinical record provides a record of the health status, including observations, measurements, history and prognosis and serves as the primary document describing healthcare services provided to the patient. The clinical record is used by the healthcare team to record, preserve and communicate the patient's progress and current treatment .		