

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

Printed: 12/04/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675976	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024
NAME OF PROVIDER OR SUPPLIER Winfield Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1108 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observation and interviews the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents for 4 of 4 resident shower rooms (Halls 100, 200, 300 and 400) observed for resident environment. The facility failed to ensure the shower rooms in the facility were clean. There was a black substance on the bathroom tiles and baseboards on 6/24/2024 and 6/25/2024. This failure could place residents at risk for an unsafe and unsanitary environment. The Findings included: During an observation on 6/24/2024 at 10:25am of the 400-hall shower room revealed an out of order sign on the door. Shower room was cluttered with multiple things being stored in the shower room such as a mechanical lift and wheelchair, and several miscellaneous items. The shower room had a black substance around room where the floor and wall met. During an observation on 6/24/2024 at 11:00am of the 100 Hall shower room revealed multiple items being stored in the shower room. Shower room smelled strongly of vinegar (CNA on the hall said the maintenance man had sprayed the shower room for gnats). Shower room had black substance around room where the floor and wall met. Observation on 6/24/2024 at 12:10pm of the 200-Hall shower room revealed miscellaneous items stored such as boxes of briefs and multiple residents' personnel items such as clothes and shower products. Staff cell phone plugged in being charged lying on top of the resident items. Shower room had black substance around room where the floor and wall met. During an interview on 6/24/2024 at 10:45am LVN R said she worked PRN and mostly on halls 100 and 400 since 2016. She said 400 hall shower room had been shut down for a long time and it did not look like it was going to be fixed. She said there had been no problems with resident receiving showers. During an observation on 6/25/2024 at 9:17 AM, the shower room on hall 300 had a black substance on the baseboards and on the shower wall. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 6/25/2204 at 9:17 AM, HSK F was on hall 300, said she had been employed at the facility for 2 months and was responsible for cleaning halls 200, 300, the resident rooms and bathrooms and the shower rooms. She observed the shower room on hall 300 and said it needed a deep clean and there was a black substance of mildew or mold on the floor and baseboards. She said she would not want to shower in a room that had mold or mildew because it was dirty. She said housekeeping were responsible for cleaning the shower rooms. During an observation and interview on 6/25/2204 at 9:26 AM, CNA G was on hall 100. She said she had been employed at the facility for 3 years and worked 6a-6p. She observed the shower room on hall 100 and said the shower room had mold on the floors and baseboards. She said she would not want to shower in a room that had mold and would not like it as it would not be clean enough for her. She said the Housekeeping Supervisor deep cleaned the shower rooms at times but did not remember the last time it was done. During an observation and interview on 6/25/2024 at 9:32 AM, the Housekeeping Supervisor said he had been employed at the facility for [AGE] years. He said the housekeeping staff were responsible for cleaning the shower rooms daily. He said he recently bought a machine to clean the shower room floors. He observed the shower room on hall 200 said the black substance that was on the floors and baseboards was black mold and it needed to be recalked, and the floors needed to be scrubbed. He said the floors had been in that condition for about 2 weeks. He said he would not want to shower in a room that had mold on the floors and was dirty. He said it would make him feel neglected. He said he was not aware of the condition of the other shower rooms but would take care of it. He said the shower room on hall 400 was out of order and in need of repairs. During an interview on 6/25/2024 at 9:40 AM, the Administrator said all the shower rooms had some kind of mold with a black substance that needed attention. She said she was aware of the shower rooms, and they should be cleaned daily. She said she was not sure what they were using to clean the shower rooms with. She said housekeeping were responsible for cleaning the shower rooms daily. She said she expected the shower rooms to be cleaned every time and would not like it if she had to use the shower room and it had mold. She said she did not go in on a regular basis to check them to make sure they were clean but going forward would inspect the shower rooms daily. She said she expected them to stay clean and look nice for the residents. A copy of a facility policy for cleaning of the facility was requested from the Administrator and none was provided.		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on interview and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 11 of 18 residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11) reviewed for abuse and neglect. The facility failed to protect Resident #1 from verbal abuse from Housekeeper A on 10/25/23 when Housekeeper A called Resident #1 a Nasty MF. The facility failed to protect Resident #1 from abuse from Resident #3 on 12/19/23 when Resident #3 hit Resident #1 on the arm. The facility failed to protect Resident #1 from abuse from Resident #6 on 8/6/23 when Resident #6 hit Resident #1 on her back. The facility failed to protect Resident #2 from abuse from Resident #3 on 2/4/24 when Resident #3 hit Resident #2 on her left shoulder. The facility failed to protect Resident #4 from abuse from Resident #5 on 10/6/23 when Resident #4 slapped Resident #5 because he grabbed her breast. The facility failed to protect Resident #7 from abuse from Resident #6 on 8/16/23 when Resident #6 hit Resident #7 on the head because he asked her to stop pulling on his wheelchair. The facility failed to protect Resident #11 from abuse from Resident #8 on 11/7/2023 when Resident #8 hit Resident #11 in the stomach with his hand. The facility failed to protect Resident #9 from abuse from MA B on 11/1/2023 when MA B pushed Resident #9 roughly in her wheelchair into her room. The facility failed to protect Resident #9 from abuse from Resident #8 on 12/30/2023. On 12/30/2023 when he was observed in the room by staff with his hands under the covers feeling of Resident #8's breasts. The facility failed to protect Resident #8 from abuse from Resident #10 between 2/26/2024 to 3/27/2024. On 2/26/2024 Resident #10 hit Resident #8 on his left arm in the dining room. On 3/25/2024 Resident #10 hit Resident #8 on his left shoulder and hand in the dining room. On 3/27/2024 Resident #10 hit Resident #8 on the hand in the dining room. The facility failed to protect Resident #8 from abuse from Resident #9 on 4/21/2024 when she was observed hitting Resident #8 on the left shoulder with a closed fist in the dining room. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An Immediate Jeopardy (IJ) situation was identified on 6/25/24 at 6:30 PM. While the IJ was removed on 6/28/24 at 5:00 PM, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of their corrective systems. These failures could place residents at risk for severe negative psychosocial outcomes which could prevent them from achieving their highest practicable physical, mental, and psychosocial well-being. Findings included: 1. Record review of the face sheet dated 6/24/24 indicated Resident #1 was an [AGE] year-old female admitted to the facility originally on 11/14/17 with the most recent readmission on 1/26/23, with diagnoses rheumatoid arthritis without rheumatoid factor (inflammation in lining of joints), hypertension (elevated blood pressure), and dementia without behavioral disturbance (mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems). Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated Resident #1's BIMS score was 15 indicating no cognitive impairment. Section E behavior of the MDS indicated Resident #1 did not have any physical, verbal, or other behavioral symptoms. Record review of Resident #1's care plan dated 11/1/23 and revised on 4/23/24 indicated Resident #1 had a behavior problem as evidenced by verbal outbursts at times with interventions that included: 1. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behaviors and interventions in behavior log. 2. When she becomes agitated intervene before the agitation escalates by guiding away from source of distress, engaging calmly in conversation, or attempting to other interventions. If response is aggressive then approach at a later time after ensuring the safety of the resident and nearby residents. 3. Intervene as necessary to protect the rights and safety of others. Remove her to an alternate location when needed to protect the rights and safety of others. 4. Psychiatric consult per indication of physician's order. Record review of facility incident report dated 8/6/23 for Resident #1, indicated Resident #1 hit Resident #6 on the hand/arm. Resident #1 then approached nursing staff and said I sure did hit her. She kicked me and I have the right to defend myself. Record review of provider investigation report dated 8/11/23 indicated Resident #1 and Resident #6 were in a physical altercation on 8/6/23 at 5:45 PM. The provider investigation report indicated Resident #1 and Resident #6 were sitting near the TV when apparently Resident #6 hit Resident #1, Resident #1 said stop and hit Resident #6 on the arm. This was originally reported that Resident #6 hit Resident #1 and Resident #1 hit Resident #6 in the head. The provider investigation report indicated the residents were kept separated until evaluated by the Psychologist and felt they were not a threat to each other or others. Record review of witness statement provided by RN EE undated indicated I noticed the resident (Resident #6) sitting in front of another resident (Resident #1), in her wheelchair. The other resident (Resident #1) was reaching her arms towards Resident #6, and I relocated Resident #6 to the nurse's station. Signed by RN EE. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of witness statement provided by Dietary Helper Z undated indicated On Sunday August 6, 2023 I was in the dish room, and Dietary Helper told me to look at Resident #6 and Resident #1. I did not see Resident #6 hit Resident #1, but I did see Resident #1 tap Resident #6 on the arm. The nurse moved Resident #6 away from Resident #1 to the nurse/s station. Signed by Dietary Helper Z. Record review of witness statement provided by Dietary Helper undated indicated On Sunday August 6, 2023, I was picking up dishes in the dining room when I heard Resident #1 tell Resident #6 to stop! I saw Resident #6 hit Resident #1 and then Resident #1 hit Resident #6 back on the arm. Then the nurse moved Resident #6 away from Resident #1. Signed by the Dietary Helper. Record review of behavioral health organization diagnostic assessment dated [DATE] at 2:49 PM indicated the reason for the referral was: conflict with another resident. Record review of Resident #1's clinical record revealed Resident was seen by behavioral health on 8/7/23 and not again until 11/6/23. Record review of provider investigation report dated 11/1/23 indicated that Resident #1 was in a verbal altercation with Housekeeper A on 10/25/23. The report indicated Resident #1, and Housekeeper A were cussing at each other. The provider investigation report indicated Housekeeper A was allowed to return to work on 10/31/23. Record review of Resident #1's progress notes from 10/23/23 through 10/27/23 revealed there was no documentation of the resident to staff incident that occurred on 10/25/23. Record review of written witness statement undated provided by Housekeeper A indicated I went to help the resident off the floor. The blood was everywhere. I was cleaning up the blood off the floor. There was a towel already there. I picked up the towel to put it in the dirty laundry. The resident (Resident #1) started cursing me, calling me a mother fucker and saying I didn't know how to do my job, because she didn't like me putting the towel in laundry. She continued cursing me calling me a nasty MF and I said no you're the nasty MF, you need to go to your room and let me do my job, but she continued calling me MF and cursing me. I just walked off. Signed by Housekeeper A. Record review of typed witness statement undated provided by Resident #1 indicated I told Housekeeper A not to put that towel with blood on it in the laundry. Put it in a plastic bag first. He then said to me, shut up you F*****g b***h! signed by Resident #1. Record review of typed witness statement undated provided by Resident #2 indicated I didn't hear everything that was said, but I heard Resident #1 say F**K you. And I heard Housekeeper A say, F**k you I heard lots of curse words. Record review of Employment Action/Disciplinary Notice Form dated 10/31/23 indicated Housekeeper A was cleaning up biohazard accident (blood) on the floor with some towels and a resident (Resident #1) started to have a verbal altercation with Housekeeper A, profanities were used by both Resident #1 and Housekeeper A during the exchange. Action to be taken: Final written action to be given to Housekeeper A as agreed upon with Administrator. Signed by Housekeeper A on 10/31/23. Record review of in-service dated 10/31/23 titled Inappropriate behavior/Language in the workplace signed by Housekeeper A. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Employment Action/Disciplinary Notice Form dated 3/27/24 for Housekeeper A revealed Housekeeper A received a written verbal warning for Professionalism in Workplace. Record review of in-service sign in sheet titled Professionalism, Inappropriate languages, Inappropriate Behaviors dated 3/27/24 signed by Housekeeper A and 1 other employee. During an interview on 6/24/24 at 10:45 AM LVN R Said she was on duty the day that Housekeeper A and Resident #1 were arguing. LVN R said she heard Housekeeper A and Resident #1 yelling and saying cuss words and went over and separated them. She said she told Housekeeper A to get off the hall and he left. She said she does not remember anything that Housekeeper A said. She said she called and reported the incident to the Administrator. She said Housekeeper A was suspended for at least 3 days. Said she never witnessed Housekeeper A talk like that to any other resident. During an interview on 6/24/24 at 10:52 AM Resident #1 said another resident had a stroke and fell on the floor and busted her head open. Resident #1 said she told Housekeeper A to get something to mop up the blood. She said Housekeeper A told her Fuck that you don't tell me what to do you don't work here. Resident #1 said Housekeeper A told her That is why you are in the nursing home because you have AIDS. Resident #1 said her, and Housekeeper A had made up and were friends now. Resident #1 said Housekeeper A still worked at the facility. During an interview on 6/24/24 at 11:00 AM Resident #2 said she remembers when Resident #1's room flooded and Housekeeper A and Resident #1 got into a rather heated argument, she said she can't remember what all was said but that they were screaming and cussing at each other. Resident #2 said Housekeeper A still worked at the facility. During an interview on 6/24/24 at 12:00 PM Housekeeper A said he had worked at the facility for about 4 years. He said there was a resident that had fallen, and blood was on the floor, so he got a towel to clean up the blood. Housekeeper A said Resident #1 said to him you can't clean up the blood with the towel. Housekeeper A said Resident #1 was going off and he told Resident #1 to leave me the hell alone. Housekeeper A said he apologized to Resident #1 but said he didn't like blood and he was trying to hurry up and get away from it. He said Resident #1 just stirs him up. Housekeeper A said he did not think he told Resident #1 to shut up, he said he might have been wrong and slipped and said it. Housekeeper A said he never told Resident #1 shut up you fucking bitch. Housekeeper A said himself and Resident #1 have not had any incidents since. Housekeeper A said he was trained on abuse before the incident. Housekeeper A said he was trained on forms of abuse after the incident. Housekeeper A said he had never had a verbal altercation with any other resident. Housekeeper A said his written statement that he had given at the time of the incident was true and correct and was signed by him. Record review of provider investigation report dated 12/26/23 and signed by the Administrator indicated Resident #1 was involved in a physical altercation with Resident #3 on 12/19/23. The provider investigation report indicated Resident #3 went into Resident #1's room and was picking up some of her stuff. Resident #1 told her to put her stuff down and to get out of her room. Resident #3 put down what she had, and slapped Resident #1 on the arm. Resident #1 slapped her back on the arm. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of facility incident report for Resident #1 dated 12/19/23 at 5:45 PM indicated This resident (Resident #1) witnessed asking another resident (Resident #3) to leave her room and put her belonging back. When other resident (Resident #3) exited Resident #1's room she proceeded to hit Resident #1 on her arm. This resident (Resident #1) seen hitting other resident (Resident #3) back on her arm. Resident #1 told nursing staff I told her to come out my room and put my stuff back and she come out and hit me. I sure did hit her back. She need to stay out my room messing with my stuff. The incident report indicated the immediate action taken: Residents separated and redirected. This resident (Resident #1) assessed, and no apparent injuries noted at this time. Resident #1 then taken into her assigned room. Record review of Resident #1's progress notes from 12/7/23 through 12/20/23 revealed there was no documentation regarding the resident-to-resident altercation that occurred on 12/19/23. Record review of witness statement provided by MA CC undated indicated I heard Resident #1 yell for Resident #3 to get out of her room. I ran to hurry Resident #3 out of her room. Resident #3 told her no and was picking up Resident #1's stuff off of her table and I'm unsure of what else she had. Resident #1 told her to put her stuff down, stop touching my stuff and to get out. I'm still trying to get Resident #3 to come out but she kept saying no this is mine, Resident #3 said no it isn't and to get out again. Resident #3 look at her and then just hit her and Resident #1 hit her back I stepped in and told them both to stop hitting. Resident #3 finally left her room. Record review of Psychological Services Progress Note for Resident #1 dated 12/21/23 at 6:21 PM indicated nursing home staff requested her to be seen due to a conflict with another residents. Signed by Psychologist. Surveyor requested behavior monitoring and interventions report for Resident #1 on 6/27/24 at 10:15 AM from Regional Nurse Consultant HH and Regional Nurse JJ. The Surveyor had not received requested documentation by the time of surveyor exit on 7/1/24. 2. Record review of the face sheet dated 6/26/24 indicated Resident #2 was a [AGE] year-old female admitted to the facility originally on 2/3/22 with the most recent readmission on 6/7/23, with diagnoses metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood), epilepsy (seizures), and generalized anxiety disorder (constant worry). Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated Resident #2's BIMS score was 15 indicating that Resident #2 was cognitively intact. Section E behavior of the MDS indicated Resident #2 did not have any physical, verbal, or other behavioral symptoms. Record review of Resident #2's care plan dated 6/14/23 and revised on 2/20/24 indicated Resident #2 had a communication problem due to a hearing deficit with interventions that included: 1. Ensure/provide a safe environment: call light in reach, adequate low glare light, bed in the lowest position and wheels locked, avoid isolation. 2. Monitor for/record confounding problems: decline in cognitive status, mood, decline in ADL . (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 6/24/24 at 11:00 AM Resident #2 said the medication aide was giving her medication and said Resident #3 walked up to them and said she was going to get her medication too. Resident #2 said Resident #3 just hit her on her left shoulder and back for no reason. Resident #2 said when Resident #3 hit her it did not hurt but it startled her. She said she was not afraid of Resident #3, and said she saw Resident #3 in the dining room later that evening, but she just stayed away from her. Resident #2 said the medication aide witnessed the incident but cannot remember who it was. Record review of provider investigation report dated 2/8/24 and signed by the Administrator indicated on 2/4/24 at 12:45 PM: Resident #3 hit Resident #2 across the back with a wet pair of pants. The provider investigation report revealed Resident #3 was taken to her room, and Resident #2 went to her room. The provider investigation report revealed the provider action taken was: continue to monitor residents for well being and safety. 2. Inservice staff on dealing with difficult behaviors and Resident #3 was transferred to another facility with a secured unit on 2/6/24. Record review of facility incident report dated 2/4/24 indicated Med aide reported to this nurse that Resident #3 hit Resident #2 on her back. The incident report indicated Resident #2 said .she was trying to help Resident #3 get back to her room and Resident #3 started yelling at her and hit her across the back just below the left shoulder. Record review of progress note dated 2/5/23 at 9:21 AM written by LVN R indicated Resident #3 hit Resident #2 on her back below her left shoulder. Record review of typed witness statement provided by Resident #2 undated indicated On Sunday, February 4, 2024 @ about 1:00 PM, I was coming down Hall 1 and Resident #3 was in the hallway between our rooms, I told Resident #3 where her room was and she told me to shut up, then hit me on my left shoulder and back. The med aid then took Resident #3 to her room. A short time earlier, my [family member] and I were visiting in my room and Resident #3 opened my door, and then shut it without incident. Signed by Resident #2. Record review of written witness statement provided by MA GG undated indicated On the date of February 4, 2024, about or between 12:15 PM - 12:30 PM, I was on hall 1 on a med pass. I saw Resident #2 coming down the hall in her wheelchair, I was close to her room waiting for her so I could give her medications. She was halfway down the hall when Resident #3 walked out of another resident room, Resident #2 was passing Resident #3 swung a wet pair of pants and hit Resident #2 across the back of her shoulders and in back of her head, I stepped in and walked Resident #3 to the nurses station and reported it to the nurse on duty LVN R. Resident #2 went to her room and LVN R went in to do an assessment, and normal activities were resumed. Signed by MA GG. Record review of a behavioral health solution psychological services progress note dated 2/5/24 indicated Resident #2 had been receiving psychiatric services weekly since 6/19/23. The psychological progress note did not address the resident-to-resident altercation on 2/4/24. Record review of behavior monitoring, and interventions report dated 2/1/24-2/29/24 revealed one day of documentation on with no behaviors observed on 2/29/24. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. Record review of the face sheet dated 6/25/24 indicated Resident #3 was a [AGE] year-old female admitted to the facility originally on 5/3/21 with the most recent readmission on 5/12/22, with diagnoses Alzheimer's disease (progressive disease that destroys memory and other important mental functions), dementia without behavioral disturbance (mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems), and cognitive communication deficit (difficulty communicating effectively). Record review of Resident #3's quarterly MDS assessment dated [DATE] indicated Resident #3's BIMS score was 3 indicating severe cognitive impairment. Section E behavior of the MDS indicated Resident #3 did not have any physical, verbal, or other behavioral symptoms. Record review of Resident #3's care plan dated 12/19/23 and revised on 3/4/24 indicated Resident #3 had a behavior problem as evidenced by resident-to-resident conflict with interventions that included: 1. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behaviors and interventions in behavior log. 2. When she becomes agitated intervene before the agitation escalates by guiding away from source of distress, engaging calmly in conversation, or attempting to other interventions. If response is aggressive then approach at a later time after ensuring the safety of the resident and nearby residents. 3. Intervene as necessary to protect the rights and safety of others. Remove her to an alternate location when needed to protect the rights and safety of others. 4. Psychiatric consult per indication of physician's order. Record review of Resident #3's progress note dated 2/5/23 at 12:45 PM written by LVN R revealed: Resident #3 hit Resident #2 on her back below her left shoulder, Resident #3 unable to explain what happened and stated, she made me mad. Resident #3 denied hitting Resident #2. Record review of facility incident report dated 2/4/24 indicated on 2/4/24 .Resident #3 hit Resident #2 on her back just below her left shoulder. Record review of a behavioral health solution psychological services progress note dated 2/5/24 indicated Resident #3 had been receiving psychiatric services weekly since 2/6/23. The psychological progress note did not address the resident-to-resident altercation on 2/4/24. Record review of Resident #3's clinical record indicated Resident #3 discharged from the facility to another nursing facility with a secured unit on 2/6/24. Surveyor requested behavior monitoring and interventions report for Resident #3 on 6/27/24 at 10:15 AM from Regional Nurse Consultant HH and Regional Nurse JJ. The Surveyor had not received requested documentation by the time of surveyor exit on 7/1/24. 4. Record review of the face sheet dated 6/25/24 indicated Resident #4 was a [AGE] year-old female admitted to the facility originally on 4/12/22 with the most recent readmission on 5/18/22, with diagnoses dementia with behavioral disturbances (mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems accompanied by agitation, depression, and psychosis), dementia without behavioral disturbance (mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems), and cognitive communication deficit (difficulty communicating effectively). (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #4's quarterly MDS assessment dated [DATE] indicated Resident #4's BIMS score was 6 indicating severe cognitive impairment. Section E behavior of the MDS indicated Resident #4 had delusions. Section E behavior of the MDS indicated Resident #4 had physical behavioral symptoms directed toward others, verbal behavioral symptoms directed toward others, and other behavioral symptoms not directed toward others that occurred 1 to 3 days. Section E wandering of the MDS indicated Resident #4 had that type of behavior daily. Record review of Resident #4's care plan dated 6/1/23 and revised on 11/1/23 indicated Resident #3 had a behavior problem as evidenced by: clothing items thrown on the floor creating increased risk for slip, trip, or falls with interventions that included: 1. When she becomes agitated intervene before the agitation escalates by guiding away from source of distress, engaging calmly in conversation, or attempting to other interventions. If response is aggressive then approach at a later time after ensuring the safety of the resident and nearby residents. 2. Intervene as necessary to protect the rights and safety of others. Remove resident to an alternate location when needed to protect the rights and safety of others. Record review of provider investigation report dated 10/13/24 signed by the Administrator indicated on 10/6/23 at 3:22 PM: .Resident #4 had told Resident #5 to quit following her, and when he continued to stand there she slapped him. The provider investigation report revealed alternate placement was being looked at and the residents were on 1:1 supervision and staff were educated on resident-to-resident altercations. Record review of incident report dated 10/6/23 for Resident #4 revealed .Resident slapped another resident in the face/neck area. Resident #4 stated he grabbed my boob so I slapped him. Record review of Resident #4's progress notes dated 10/4/23 through 10/7/23 revealed there was no documentation of the resident-to-resident altercation that occurred on 10/6/23. Record review of staffing schedules dated 10/8/23 through 10/17/23 indicated: 10/6/23- no staffing schedule provided to show 1 on 1 monitoring of Resident #4. 10/7/23- no staffing schedule provided to show 1 on 1 monitoring of Resident #4. 10/9/23-Showed staffing 1 on 1 coverage for Resident #4 unknown hours. 10/11/23-Showed staffing 1 on 1 coverage for Resident #4 from 7:00 AM to 4:30 PM and 6:00 PM to 6:00AM. 10/12/23-Showed staffing 1 on 1 coverage for Resident #4 from 7:00 AM to 4:30 PM and unknown after that. 10/15/23- Showed staffing 1 on 1 coverage for Resident #4 from 7:00 AM to 4:30 PM, and 6:00 PM to 6:00 AM. 10/17/23- No 1 on 1 staffing coverage for Resident #4 shown. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #4's clinical record indicated she had been receiving behavioral health solution psychological services weekly from 8/18/23 to 10/23/23. Record review of behavioral health solution psychological services progress note dated 10/9/23 at 3:05 PM indicated: Patient's Response to Intervention: Discussed the issue she had with another resident and she has no memory of the incident. The progress note did not indicate when the incident occurred or with who. The progress note did not address 1 on 1 monitoring with Resident #4. Record review of behavioral health solution psychological services progress note dated 10/16/23 did not address the resident-to-resident altercation or 1 on 1 monitoring with Resident #4. Record review of behavioral health solution psychological services progress note dated 10/23/23 did not address the resident-to-resident altercation or 1 on 1 monitoring with Resident #4. The progress note revealed Resident #4 was not seen by the psychologist due to Resident #4 being transferred to another facility. Record review of Resident #4's clinical record indicated Resident #4 discharged from the facility on 10/16/23. Surveyor requested behavior monitoring and interventions report for Resident #4 on 6/27/24 at 10:15 AM from Regional Nurse Consultant HH and Regional Nurse JJ. The Surveyor had not received requested documentation by the time of surveyor exit on 7/1/24. 5. Record review of the face sheet dated 6/25/24 indicated Resident #5 was a [AGE] year-old male admitted to the facility originally on 1/20/23, with diagnoses benign neoplasm of meninges (brain tumor), type 2 diabetes (high blood sugar), and cognitive communication deficit (difficulty communicating effectively). Record review of Resident #5's quarterly MDS assessment dated [DATE] indicated Resident #5's BIMS score was 00 indicating severe cognitive impairment. Section E behavior of the MDS indicated Resident #5 did not have any physical, verbal, or other behavioral symptoms. Record review of Resident #5's care plan dated 1/25/23 and revised on 3/1/24 indicated Resident #5 wanders related to cognitive impairment and is at risk for injury. He wanders around facility attempting to go in other residents rooms. Interventions included: 1. Redirect if he enters a restricted area. 2. Monitor him for tailgating when visitors are in the building or on the unit. Record review of Resident #5's progress notes dated between 10/2/23 through 10/7/23 revealed there was no documentation of the resident-to-resident altercation that occurred on 10/6/23. Record review of provider investigation report dated 10/13/24 signed by the Administrator indicated on 10/6/23 at 3:22 PM: .Resident #4 had told Resident #5 to quit following her, and when he continued to stand there she slapped him. The provider investigation report revealed alternate placement was being looked at and the residents were on 1:1 supervision and staff were educated on resident-to-resident altercations. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of incident report dated 10/6/23 for Resident #5 revealed .another resident slapped him across the face neck area. Resident #5 stated I was walking down the hall and then she hit me and pointed to the left side of his face. Record review of staffing schedules dated 10/8/23 through 10/17/23 (no staffing schedules provided prior to 10/8/23 or after 10/17/23) indicated: 10/6/23- no staffing schedule provided to show 1 on 1 monitoring of Resident #5. 10/7/23- no staffing schedule provided to show 1 on 1 monitoring of Resident #5. 10/9/23-Showed staffing 1 on 1 coverage for Resident #5 from 6-12. 10/12/23- Staffing showed 1 on 1 coverage for Resident #5 from 6:40 AM to 5:00PM and 6:00 PM to 6:00AM. 10/13/23- Showed staffing 1 on 1 coverage for Resident #5 7:00 AM to 6:00 PM and 6:00 PM to 6:00 AM. 10/14/23-Showed staffing 1 on 1 coverage for Resident #5 11:00am to 6:00 PM and 6:00 PM to 6:00 AM. 10/17/23- Showed staffing 1 on 1 coverage for Resident #5 6-?. Record review of behavioral health solution psychological services progress note date 10/16/23 did not address 1 on 1 monitoring or the resident-to-resident altercation that occurred on 10/6/23. Surveyor requested behavior monitoring and interventions report for Resident #5 on 6/27/24 at 10:15 AM from Regional Nurse Consultant HH and Regional Nurse JJ. The Surveyor had not received requested documentation by the time of surveyor exit on 7/1/24. 6. Record review of the face sheet dated 6/25/24 indicated Resident #6 was a [AGE] year-old female admitted to the facility originally on 4/24/18 with the most recent readmission on 12/5/22, with diagnoses Alzheimer's disease (progressive disease that destroys memory and other important mental functions), dementia without behavioral disturbances (mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems), and cognitive communication deficit (difficulty communicating effectively). Record review of Resident #6's quarterly MDS assessment dated [DATE] indicated Resident #6's BIMS score was 3 indicating severe cognitive impairment. Section E behavior of the MDS indicated Resident #6 had physical behavioral symptoms directed toward others that occurred 1 to 3 days. (continued on next page)		

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #6's care plan dated 1/29/23 and revised on 6/20/23 indicated Resident #6 had a behavior problem as evidenced by: Incident occurring on 1/29/23 with resident-to-resident altercation with interventions that included: 1. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behaviors and interventions in behavior log. 2. When she becomes agitated intervene before the agitation escalates by guiding away from source of distress, engaging calmly in conversation, or attempting to other interventions. If response is aggressive then approach at a later time after ensuring the safety of the resident and nearby residents. 2. Intervene as necessary to protect the rights and safety of others. Remove resident to an alternate location when needed to protect the rights and safety of others. Record review of Resident #6's progress notes dated 8/14/23 through 8/16/23 revealed there was no documentation of the resident-to-resident altercation that occurred on 8/16/23. Record review of provider investigation report dated 8/21/23 signed by the Administrator indicated on 8/1 [TRUNCATED]		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on interview and record review the facility failed to develop and implement written policies and procedures that prohibited and prevented abuse, neglect, and exploitation of residents and misappropriation of resident property for 11 of 18 residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11) reviewed for abuse policies. The facility failed to protect Resident #1 from verbal abuse from Housekeeper A on 10/25/23 when Housekeeper A called Resident #1 a Nasty MF. The facility failed to protect Resident #1 from abuse from Resident #6 on 8/6/23 when Resident #6 hit Resident #1 on her back. The facility failed to protect Resident #1 from abuse from Resident #3 on 12/19/23 when Resident #3 hit Resident #1 on the arm. The facility failed to protect Resident #2 from abuse from Resident #3 on 2/4/24 when Resident #3 hit Resident #2 on her left shoulder. The facility failed to protect Resident #4 from abuse from Resident #5 on 10/6/23 when Resident #4 slapped Resident #5 because he grabbed her breast. The facility failed to protect Resident #7 from abuse from Resident #6 on 8/16/23 when Resident #6 hit Resident #7 on the head because he asked her to stop pulling on his wheelchair. The facility failed to protect Resident #11 from abuse from Resident #8 on 11/7/2023 when Resident #8 hit Resident #11 in the stomach with his hand. The facility failed to protect Resident #9 from abuse from MA B on 11/1/2023 when MA B pushed Resident #9 roughly in her wheelchair into her room. The facility failed to protect Resident #9 from abuse from Resident #8 on 12/30/2023. On 12/30/2023 when he was observed in the room by staff with his hands under the covers feeling of Resident #8's breasts. The Administrator failed to report an incident of abuse on 12/30/2023 when Resident #8 was found in the room of Resident #9 when he was observed in the room by staff with his hands under the covers feeling of Resident #8's breasts. The facility failed to protect Resident #8 from abuse from Resident #10 between 2/26/2024 to 3/27/2024. On 2/26/2024 Resident #10 hit Resident #8 on his left arm in the dining room. On 3/25/2024 Resident #10 hit Resident #8 on his left shoulder and hand in the dining room. On 3/27/2024 Resident #10 hit Resident #8 on the hand in the dining room. The facility failed to protect Resident #8 from abuse from Resident #9 on 4/21/2024 when she was observed hitting Resident #8 on the left shoulder with a closed fist in the dining room. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An Immediate Jeopardy (IJ) situation was identified on 6/25/24 at 6:30 PM. While the IJ was removed on 6/28/24 at 5:00 PM, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of their corrective systems. These failures could place residents at risk of abuse which could lead to further abuse and neglect of other residents. Findings included: 1. Record review of the face sheet dated 6/24/24 indicated Resident #1 was an [AGE] year-old female admitted to the facility originally on 11/14/17 with the most recent readmission on 1/26/23, with diagnoses rheumatoid arthritis without rheumatoid factor (inflammation in lining of joints), hypertension (elevated blood pressure), and dementia without behavioral disturbance (mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems). Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated Resident #1's BIMS score was 15 indicating no cognitive impairment. Section E behavior of the MDS indicated Resident #1 did not have any physical, verbal or other behavioral symptoms. Record review of Resident #1's care plan dated 11/1/23 and revised on 4/23/24 indicated Resident #1 had a behavior problem as evidenced by verbal outbursts at times with interventions that included: 1. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behaviors and interventions in behavior log. 2. When she becomes agitated intervene before the agitation escalates by guiding away from source of distress, engaging calmly in conversation, or attempting to other interventions. If response is aggressive then approach at a later time after ensuring the safety of the resident and nearby residents. 3. Intervene as necessary to protect the rights and safety of others. Remove her to an alternate location when needed to protect the rights and safety of others. 4. Psychiatric consult per indication of physician's order. Record review of provider investigation report dated 8/11/23 indicated Resident #1 and Resident #6 were in a physical altercation on 8/6/23 at 5:45 PM. The provider investigation report indicated Resident #1 and Resident #6 were sitting near the TV when apparently Resident #6 hit Resident #1, Resident #1 said stop and hit Resident #6 on the arm. This was originally reported that Resident #6 hit Resident #1 and Resident #1 hit Resident #6 in the head. The provider investigation report indicated the residents were kept separated until evaluated by the Psychologist and felt they were not a threat to each other or others. Record review of facility incident report dated 8/6/23 for Resident #1, indicated Resident #1 hit Resident #6 on the hand/arm. Resident #1 then approached nursing staff and said I sure did hit her. She kicked me and I have the right to defend myself. Record review of witness statement provided by RN EE undated indicated I noticed the resident (Resident #6) sitting in front of another resident (Resident #1), in her wheelchair. The other resident (Resident #1) was reaching her arms towards Resident #6, and I relocated Resident #6 to the nurse's station. Signed by RN EE. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of witness statement provided by Dietary Helper Z undated indicated On Sunday August 6, 2023 I was in the dish room and Dietary Helper told me to look at Resident #6 and Resident #1. I didn't see Resident #6 hit Resident #1, but I did see Resident #1 tap Resident #6 on the arm. The nurse moved Resident #6 away from Resident #1 to the nurse/s station. Signed by Dietary Helper Z. Record review of witness statement provided by Dietary Helper undated indicated On Sunday August 6, 2023, I was picking up dishes in the dining room when I heard Resident #1 tell Resident #6 to stop! I saw Resident #6 hit Resident #1 and then Resident #1 hit Resident #6 back on the arm. Then the nurse moved Resident #6 away from Resident #1. Signed by the Dietary Helper. Record review of behavioral health organization diagnostic assessment dated [DATE] at 2:49 PM indicated the reason for the referral was: conflict with another resident. Record review of Resident #1's clinical record revealed Resident was seen by behavioral health on 8/7/23 and not again until 11/6/23. Record review of provider investigation report dated 11/1/23 indicated that Resident #1 was in a verbal altercation with Housekeeper A on 10/25/23. The report indicated Resident #1, and Housekeeper A were cussing at each other. The provider investigation report indicated Housekeeper A was allowed to return to work on 10/31/23. Record review of Resident #1's progress notes dated between 10/23/23 through 10/27/23 revealed there was not a incident documented in the progress notes that occurred on 10/25/23. Record review of written witness statement undated provided by Housekeeper A indicated I went to help the resident off the floor. The blood was everywhere. I was cleaning up the blood off the floor. There was a towel already there. I picked up the towel to put it in the dirty laundry. The resident (Resident #1) started cursing me, calling me a mother fucker and saying I didn't know how to do my job, because she didn't like me putting the towel in laundry. She continued cursing me calling me a nasty MF and I said no you're the nasty MF, you need to go to your room and let me do my job, but she continued calling me MF and cursing me. I just walked off. Signed by Housekeeper A. Record review of typed witness statement undated provided by Resident #1 indicated I told Housekeeper A not to put that towel with blood on it in the laundry. Put it in a plastic bag first. He then said to me, shut up you F*****g b***h! signed by Resident #1. Record review of typed witness statement undated provided by Resident #2 indicated I didn't hear everything that was said, but I heard Resident #1 say F**K you. And I heard Housekeeper A say, F**k you I heard lots of curse words. Record review of Employment Action/Disciplinary Notice Form dated 10/31/23 indicated Housekeeper A was cleaning up biohazard accident (blood) on the floor with some towels and a resident (Resident #1) started to have a verbal altercation with Housekeeper A, profanities were used by both Resident #1 and Housekeeper A during the exchange. Action to be taken: Final written action to be given to Housekeeper A as agreed upon with Administrator. Signed by Housekeeper A on 10/31/23. Record review of in-service dated 10/31/23 titled Inappropriate behavior/Language in the workplace signed by Housekeeper A. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of provider investigation report dated 12/26/23 and signed by the Administrator indicated Resident #1 was involved in a physical altercation with Resident #3 on 12/19/23. The provider investigation report indicated Resident #3 went into Resident #1's room and was picking up some of her stuff. Resident #1 told her to put her stuff down and to get out of her room. Resident #3 put down what she had, and slapped Resident #1 on the arm. Resident #1 slapped her back on the arm. Record review of facility incident report for Resident #1 dated 12/19/23 at 5:45 PM indicated This resident (Resident #1) witnessed asking another resident (Resident #3) to leave her room and put her belonging back. When other resident (Resident #3) exited Resident #1's room she proceeded to hit Resident #1 on her arm. This resident (Resident #1) seen hitting other resident (Resident #3) back on her arm. Resident #1 told nursing staff I told her to come out my room and put my stuff back and she come out and hit me. I sure did hit her back. She need to stay out my room messing with my stuff. The incident report indicated the immediate action taken: Residents separated and redirected. This resident (Resident #1) assessed and no apparent injuries noted at this time. Resident #1 then taken into her assigned room. Record review of Resident #1's progress notes dated between 12/7/23 and 12/20/23 revealed there was no documentation regarding the resident-to-resident altercation that occurred on 12/19/23. Record review of witness statement provided by MA CC undated indicated I heard Resident #1 yell for Resident #3 to get out of her room. I ran to hurry Resident #3 out of her room. Resident #3 told her no and was picking up Resident #1's stuff off of her table and I'm unsure of what else she had. Resident #1 told her to put her stuff down, stop touching my stuff and to get out. I'm still trying to get Resident #3 to come out but she kept saying no this is mine, Resident #3 said no it isn't and to get out again. Resident #3 look at her and then just hit her and Resident #1 hit her back I stepped in and told them both to stop hitting. Resident #3 finally left her room. Record review of Psychological Services Progress Note for Resident #1 dated 12/21/23 at 6:21 PM indicated nursing home staff requested her to be seen due to a conflict with another residents. Signed by Psychologist. Surveyor was not provided with requested behavior monitoring and interventions report for Resident #1 by the time of surveyor exit on 7/1/24. 2. Record review of the face sheet dated 6/26/24 indicated Resident #2 was a [AGE] year-old female admitted to the facility originally on 2/3/22 with the most recent readmission on 6/7/23, with diagnoses metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood), epilepsy (seizures), and generalized anxiety disorder (constant worry). Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated Resident #2's BIMS score was 15 indicating that Resident #2 was cognitively intact. Section E behavior of the MDS indicated Resident #2 did not have any physical, verbal or other behavioral symptoms. Record review of Resident #2's care plan dated 6/14/23 and revised on 2/20/24 indicated Resident #2 had a communication problem due to a hearing deficit with interventions that included: 1. Ensure/provide a safe environment: call light in reach, adequate low glare light, bed in the lowest position and wheels locked, avoid isolation. 2. Monitor for/record confounding problems: decline in cognitive status, mood, decline in ADL . (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of provider investigation report dated 2/8/24 and signed by the Administrator indicated on 2/4/24 at 12:45 PM: Resident #3 hit Resident #2 across the back with a wet pair of pants. The provider investigation report revealed Resident #3 was taken to her room, and Resident #2 went to her room. The provider investigation report revealed the provider action taken was: continue to monitor residents for well being and safety. 2. Inservice staff on dealing with difficult behaviors and Resident #3 was transferred to another facility with a secured unit on 2/6/24. Record review of facility incident report dated 2/4/24 indicated Med aide reported to this nurse that Resident #3 hit Resident #2 on her back. The incident report indicated Resident #2 said .she was trying to help Resident #3 get back to her room and Resident #3 started yelling at her and hit her across the back just below the left shoulder. Record review of progress note dated 2/5/23 at 9:21 AM written by LVN R indicated Resident #3 hit Resident #2 on her back below her left shoulder. Record review of typed witness statement provided by Resident #2 undated indicated On Sunday, February 4, 2024 @ about 1:00 PM, I was coming down Hall 1 and Resident #3 was in the hallway between our rooms, I told Resident #3 where her room was and she told me to shut up, then hit me on my left shoulder and back. The med aid then took Resident #3 to her room. A short time earlier, my husband and I were visiting in my room and Resident #3 opened my door, and then shut it without incident. Signed by Resident #2. Record review of written witness statement provided by MA GG undated indicated On the date of February 4, 2024, about or between 12:15 PM - 12:30 PM, I was on hall 1 on a med pass. I saw Resident #2 coming down the hall in her wheelchair, I was close to her room waiting for her so I could give her meds. She was halfway down the hall when Resident #3 walked out of another resident room, Resident #2 was passing Resident #3 swung a wet pair of pants and hit Resident #2 across the back of her shoulders and in back of her head, I stepped in and walked Resident #3 to the nurses station and reported it to the nurse on duty LVN R. Resident #2 went to her room and LVN R went in to do an assessment, and normal activities were resumed. Signed by MA GG. Record review of a behavioral health solution psychological services progress note dated 2/5/24 indicated Resident #2 had been receiving psychiatric services weekly since 6/19/23. The psychological progress note dated 2/5/24 did not address the resident-to-resident altercation on 2/4/24. Record review of behavior monitoring, and interventions report dated 2/1/24-2/29/24 revealed one day of documentation with no behaviors observed on 2/29/24. 3. Record review of the face sheet dated 6/25/24 indicated Resident #3 was a [AGE] year-old female admitted to the facility originally on 5/3/21 with the most recent readmission on 5/12/22, with diagnoses Alzheimer's disease (progressive disease that destroys memory and other important mental functions), dementia without behavioral disturbance (mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems), and cognitive communication deficit (difficulty communicating effectively). Record review of Resident #3's quarterly MDS assessment dated [DATE] indicated Resident #3's BIMS score was 3 indicating severe cognitive impairment. Section E behavior of the MDS indicated Resident #3 did not have any physical, verbal or other behavioral symptoms. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #3's care plan dated 12/19/23 and revised on 3/4/24 indicated Resident #3 had a behavior problem as evidenced by resident-to-resident conflict with interventions that included: 1. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behaviors and interventions in behavior log. 2. When she becomes agitated intervene before the agitation escalates by guiding away from source of distress, engaging calmly in conversation, or attempting to other interventions. If response is aggressive then approach at a later time after ensuring the safety of the resident and nearby residents. 3. Intervene as necessary to protect the rights and safety of others. Remove her to an alternate location when needed to protect the rights and safety of others. 4. Psychiatric consult per indication of physician's order. Record review of Resident #3's progress note dated 2/5/23 at 12:45 PM written by LVN R revealed: Resident #3 hit Resident #2 on her back below her left shoulder, Resident #3 unable to explain what happened and stated, she made me mad. Resident #3 denied hitting Resident #2. Record review of provider investigation report dated 2/8/24 and signed by the Administrator indicated on 2/4/24 at 12:45 PM: Resident #3 hit Resident #2 across the back with a wet pair of pants. The provider investigation report revealed Resident #3 was taken to her room, and Resident #2 went to her room. The provider investigation report revealed the provider action taken was: continue to monitor residents for wellbeing and safety. 2. Inservice staff on dealing with difficult behaviors and Resident #3 was transferred to another facility with a secured unit on 2/6/24. Record review of facility incident report dated 2/4/24 indicated on 2/4/24 .Resident #3 hit Resident #2 on her back just below her left shoulder. Record review of a behavioral health solution psychological services progress note dated 2/5/24 indicated Resident #3 had been receiving psychiatric services weekly since 2/6/23. The psychological progress note dated 2/5/24 did not address the resident-to-resident altercation on 2/4/24. Record review of Resident #3's clinical record indicated Resident #3 discharged from the facility to another nursing facility with a secured unit on 2/6/24. Surveyor was not provided with requested behavior monitoring and interventions report for Resident #3 by the time of surveyor exit on 7/1/24. 4. Record review of the face sheet dated 6/25/24 indicated Resident #4 was a [AGE] year-old female admitted to the facility originally on 4/12/22 with the most recent readmission on 5/18/22, with diagnoses dementia with behavioral disturbances (mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems accompanied by agitation, depression, and psychosis), dementia without behavioral disturbance (mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems), and cognitive communication deficit (difficulty communicating effectively). (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #4's quarterly MDS assessment dated [DATE] indicated Resident #4's BIMS score was 6 indicating severe cognitive impairment. Section E behavior of the MDS indicated Resident #4 had delusions. Section E behavior of the MDS indicated Resident #4 had physical behavioral symptoms directed toward others, verbal behavioral symptoms directed toward others, and other behavioral symptoms not directed toward others that occurred 1 to 3 days. Section E wandering of the MDS indicated Resident #4 had that type of behavior daily. Record review of Resident #4's care plan dated 6/1/23 and revised on 11/1/23 indicated Resident #3 had a behavior problem as evidenced by: clothing items thrown on the floor creating increased risk for slip, trip, or falls with interventions that included: 1. When she becomes agitated intervene before the agitation escalates by guiding away from source of distress, engaging calmly in conversation, or attempting to other interventions. If response is aggressive then approach at a later time after ensuring the safety of the resident and nearby residents. 2. Intervene as necessary to protect the rights and safety of others. Remove resident to an alternate location when needed to protect the rights and safety of others. Record review of Resident #4's progress notes dated 10/4/23 through 10/7/23 revealed there was no documentation of the resident-to-resident altercation that occurred on 10/6/23. Record review of provider investigation report dated 10/13/24 signed by the Administrator indicated on 10/6/23 at 3:22 PM: .Resident #4 had told Resident #5 to quit following her, and when he continued to stand there, she slapped him. The provider investigation report revealed alternate placement was being looked at and the residents were on 1:1 supervision and staff were educated on resident-to-resident altercations. Record review of incident report dated 10/6/23 for Resident #4 revealed .Resident slapped another resident in the face/neck area. Resident #4 stated he grabbed my boob so I slapped him. Record review of staffing schedules dated 10/8/23 through 10/17/23 indicated: 10/6/23- no staffing schedule provided to show 1 on 1 monitoring of Resident #4. 10/7/23- no staffing schedule provided to show 1 on 1 monitoring of Resident #4. 10/9/23-Showed staffing 1 on 1 coverage for Resident #4 unknown hours. 10/11/23-Showed staffing 1 on 1 coverage for Resident #4 from 7:00 AM to 4:30 PM and 6:00 PM to 6:00AM. 10/12/23-Showed staffing 1 on 1 coverage for Resident #4 from 7:00 AM to 4:30 PM and unknown after that. 10/15/23- Showed staffing 1 on 1 coverage for Resident #4 from 7:00 AM to 4:30 PM, and 6:00 PM to 6:00 AM. 10/17/23- No 1 on 1 staffing coverage for Resident #4 shown. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #4's clinical record indicated she had been receiving behavioral health solution psychological services weekly from 8/18/23 to 10/23/23. Record review of behavioral health solution psychological services progress note dated 10/9/23 at 3:05 PM indicated: Patient's Response to Intervention: Discussed the issue she had with another resident and she has no memory of the incident. The progress note did not indicate when the incident occurred or with who. The progress note did not address 1 on 1 monitoring with Resident #4. Record review of behavioral health solution psychological services progress note dated 10/16/23 did not address the resident-to-resident altercation or 1 on 1 monitoring with Resident #4. Record review of behavioral health solution psychological services progress note dated 10/23/23 did not address the resident-to-resident altercation or 1 on 1 monitoring with Resident #4. The progress note revealed Resident #4 was not seen by the psychologist due to Resident #4 being transferred to another facility. Record review of Resident #4's clinical record indicated Resident #4 discharged from the facility on 10/16/23. Surveyor was not provided with requested behavior monitoring and interventions report for Resident #4 by the time of surveyor exit on 7/1/24. 5. Record review of the face sheet dated 6/25/24 indicated Resident #5 was a [AGE] year-old male admitted to the facility originally on 1/20/23, with diagnoses benign neoplasm of meninges (brain tumor), type 2 diabetes (high blood sugar), and cognitive communication deficit (difficulty communicating effectively). Record review of Resident #5's quarterly MDS assessment dated [DATE] indicated Resident #5's BIMS score was 00 indicating severe cognitive impairment. Section E behavior of the MDS indicated Resident #5 did not have any physical, verbal or other behavioral symptoms. Record review of Resident #5's care plan dated 1/25/23 and revised on 3/1/24 indicated Resident #5 wanders related to cognitive impairment and is at risk for injury. He wanders around facility attempting to go in other residents rooms. Interventions included: 1. Redirect if he enters a restricted area. 2. Monitor him for tailgating when visitors are in the building or on the unit. Record review of Resident #5's progress notes dated between 10/2/23 through 10/7/23 revealed there was no documentation of the resident-to-resident altercation that occurred on 10/6/23. Record review of provider investigation report dated 10/13/24 signed by the Administrator indicated on 10/6/23 at 3:22 PM: .Resident #4 had told Resident #5 to quit following her, and when he continued to stand there she slapped him. The provider investigation report revealed alternate placement was being looked at and the residents were on 1:1 supervision and staff were educated on resident-to-resident altercations. Record review of incident report dated 10/6/23 for Resident #5 revealed .another resident slapped him across the face neck area. Resident #5 stated I was walking down the hall and then she hit me and pointed to the left side of his face. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of staffing schedules dated 10/8/23 through 10/17/23 (no staffing schedules provided prior to 10/8/23 or after 10/17/23) indicated: 10/6/23- no staffing schedule provided to show 1 on 1 monitoring of Resident #5. 10/7/23- no staffing schedule provided to show 1 on 1 monitoring of Resident #5. 10/9/23-Showed staffing 1 on 1 coverage for Resident #5 from 6-12. 10/12/23- Staffing showed 1 on 1 coverage for Resident #5 from 6:40 AM to 5:00PM and 6:00 PM to 6:00AM. 10/13/23- Showed staffing 1 on 1 coverage for Resident #5 7:00 AM to 6:00 PM and 6:00 PM to 6:00 AM. 10/14/23-Showed staffing 1 on 1 coverage for Resident #5 11:00am to 6:00 PM and 6:00 PM to 6:00 AM. 10/17/23- Showed staffing 1 on 1 coverage for Resident #5 6-?. Record review of behavioral health solution psychological services progress note date 10/16/23 did not address 1 on 1 monitoring or the resident-to-resident altercation that occurred on 10/6/23. Surveyor was not provided with requested behavior monitoring and interventions report for Resident #5 by the time of surveyor exit on 7/1/24. 6. Record review of the face sheet dated 6/25/24 indicated Resident #6 was a [AGE] year-old female admitted to the facility originally on 4/24/18 with the most recent readmission on 12/5/22, with diagnoses Alzheimer's disease (progressive disease that destroys memory and other important mental functions), dementia without behavioral disturbances (mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems), and cognitive communication deficit (difficulty communicating effectively). Record review of Resident #6's quarterly MDS assessment dated [DATE] indicated Resident #6's BIMS score was 3 indicating severe cognitive impairment. Section E behavior of the MDS indicated Resident #6 had physical behavioral symptoms directed toward others that occurred 1 to 3 days. Record review of Resident #6's care plan dated 1/29/23 and revised on 6/20/23 indicated Resident #6 had a behavior problem as evidenced by: Incident occurring on 1/29/23 with resident-to-resident altercation with interventions that included: 1. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behaviors and interventions in behavior log. 2. When she becomes agitated intervene before the agitation escalates by guiding away from source of distress, engaging calmly in conversation, or attempting to other interventions. If response is aggressive then approach at a later time after ensuring the safety of the resident and nearby residents. 2. Intervene as necessary to protect the rights and safety of others. Remove resident to an alternate location when needed to protect the rights and safety of others. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #6's progress notes dated 8/14/23 through 8/16/23 revealed there was no documentation of the resident-to-resident altercation that occurred on 8/16/23. Record review of provider investigation report dated 8/21/23 signed by the Administrator indicated on 8/16/23 at 2:00 PM: While Resident #7 was sitting in the TV room watching tv Resident #6 grabbed hold of his chair to pull herself forward. Resident #7 told her to stop and Resident #6 hit him on the back of the head. The provider investigation report revealed Resident #6 was placed on 1 on 1 supervision since the incident and the doctor ordered Rexulti to see if it would help with Resident #6's behaviors. Record review of incident report dated 8/16/23 for Resident #6 revealed Resident #6 was sitting in dining room in wheelchair when she wheeled over to another resident and started pulling on his wheelchair. Resident #7 told Resident #6 not to pull on his chair and then Resident #6 hit resident #7 on the back of the head with her hand. Surveyor was not provided staffing schedule sheets showing staffing schedule for 1 to 1 monitoring for Resident #6 by the time of surveyor exit on 7/1/24. Record review of behavioral health solutions psychologists progress note dated 8/7/23, 11/6/23 and 2/27/24 revealed Resident #6 was not seen by psychiatric services in reference to the resident-to-resident altercation involving Resident #7. Record review of Resident #6's clinical record indicated Resident #6 was discharged to another nursing facility on 10/14/23. Surveyor was not provided with requested behavior monitoring and interventions report for Resident #6 by the time of surveyor exit on 7/1/24. 7. Record review of the face sheet dated 6/27/24 indicated Resident #7 was a [AGE] year-old male admitted to the facility originally on 8/4/23, with diagnoses transient cerebral ischemic attack (stroke), acute respiratory failure with hypoxia (problems breathing), and cognitive communication deficit (difficulty communicating effectively). Record review of Resident #7's quarterly MDS assessment dated [DATE] indicated Resident #7's BIMS score was 9 indicating moderate cognitive impairment. Section E behavior of the MDS indicated Resident #7 did not have any physical, verbal, or other behavioral symptoms. Record review of Resident #7's care plan dated 8/5/23 and revised on 9/1/23 indicated Resident #7 had fragile skin related to the aging process and was at risk for bruising easily and skin tears with intervention that included: 1. Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against sharp or hard surfaces. Record review of provider investigation report dated 8/21/23 signed by the Administrator indicated on 8/16/23 at 2:00 PM: While Resident #7 was sitting in the TV room watching tv Resident #6 grabbed hold of his chair to pull herself forward. Resident #7 told her to stop and Resident #6 hit him on the back of the head. The provider investigation report revealed Resident #6 was placed on 1 on 1 supervision since the incident and the doctor ordered Rexulti to see if it would help with Resident #6's behaviors. (continued on next page)		

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

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #7's progress note dated 8/16/23 written by LVN HH at 6:25 PM revealed Resident reported to this nurse that while he was sitting in the dining room watching TV. Another resident began pulling on his wheelchair. He reported that when he told her no, the other resident hit him in the back of his head . Record review of incident report dated 8/16/23 for Resident #7 indicated: Resident #7 was hit in [TRUNCATED]		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, or mistreatment are reported immediately or not later than 2 hours for 2 of 15 residents reviewed for abuse and neglect. (Residents #8 and #9) The Administrator failed to report an allegation of abuse on 12/30/2023 when Resident #8 was observed in the room of Resident #9 with his hands under the covers by staff feeling of Resident #9's breasts. This failure could place residents at risk for further abuse and neglect. Findings included: 1. Record review of a face sheet for Resident #9 dated 6/25/2024 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions). Record review of a Quarterly MDS for Resident #9 dated 3/22/2024 indicated she had severe impairment in thinking with a BIMS score of 5. She required set up assistance with eating and partial/moderate assistance with personal hygiene, toileting hygiene and dressing. Record review of a care plan for Resident #9 revised 6/9/2022 indicated she had severe cognitive impairment related to dementia with interventions that she needed supervision/assistance with all decision making. 2. Record review of a face sheet for Resident #8 dated 6/30/2024 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of intellectual disabilities (significant limitations in both thinking and learning), and major depressive disorder (persistent feeling of sadness and loss of interest that can interfere with daily life),. Record review of a Quarterly MDS Assessment for Resident #8 dated 2/14/2024 indicated he had severe impairment in thinking with a BIMS score of 00. He did not have any physical behaviors directed toward others. Record review of an Annual MDS Assessment for Resident #8 dated 3/21/2024 indicated he had severe impairment in thinking with a BIMS score of 00. He did not have any physical behaviors directed toward others. Record review of a care plan for Resident #8 revised on 2/26/2024 indicated he had a problem of inappropriate sexual behaviors and or other related behaviors in the presence of others with interventions to intervene as necessary to protect the rights and safety of others. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a nurse progress note for Resident #8 dated 12/30/2023 at 1:30 AM by LVN J indicated, Resident found in female residents room, had hands under cover and feeling of resident, female resident wasn't upset at this time, resident removed from room and taken to his room and put to bed, Adm notified of incident. During an interview on 6/25/2024 at 11:20 AM, the Administrator said Resident #8 was care planned for touching a female resident inappropriately and that resident was Resident #9, but that Resident #8 only patted her on the leg above the cover and staff reported it to her. During a phone interview on 6/25/2024 at 11:59 AM, LVN J said she and another aide were on the hall and heard a chair move in Resident #9's room and looked in her room as they periodically checked on her. She said Resident #8 had his hands under the covers and was feeling of her breasts. She said Resident #9 was awake. She said they immediately removed Resident #8 from the room and took him to his room. She said she called the Administrator and DON and told Resident #8 that he could not go to her room anymore. She said the Administrator notified the POA for Resident #8 and she notified the Administrator She said she stayed with Resident #9 for a few minutes, and she was able to go back to sleep. She said conducted an assessment on Resident #9 and did not find anything. She said she reported the incident to the Administrator right after it happened. She said after she talked to the Administrator, they placed Resident #8 on 15-minute monitoring for a few days. During an interview on 6/25/2024 at 12:07 PM, the DON said Resident #8 was care planned for touching female residents inappropriately because sometimes he would touch them on their hands or legs when in the dining room. She said the RP of Resident #9 had called the Administrator and told her on one occasion that Resident #8 was in the room of Resident #9 and touched her and the RP saw it on camera that he was in the room. She said the Administrator said Resident #9 did not seemed disturbed by the touching. She said she was not aware of the incident where the nurse documented that Resident #8 had touched a female resident inappropriately on 12/30/2023. She said after reviewing the progress note dated 12/30/2023, the incident should have been investigated. She said that it was abuse. She said Resident #8 had a tendency to touch inappropriately but only on the hands and arms, and sometimes he would go to the doors of female residents as he was a wanderer. She said the incident should have been reported right after it happened to the Administrator who was the abuse coordinator. During an interview on 6/25/2024 at 12:18 PM, the Administrator stated the progress note dated 12/30/2023 for Resident #8 was referring to Resident #9. She said she was aware of the incident and had called the family member and reported that Resident #8 was in the room and asked her if she had seen anything on the camera in the Resident #9's room. She said the family member informed her that she did see Resident #8 in the room and her mother seemed fine and was not bothered by it. She said Resident #9 had a BIMS that was very low. When questioned what she did following the phone conversation with the RP, she said she could not recall exactly what she did. She said she did not report the incident to the state agency because Resident #9 did not have any emotional side effects from the incident. She said Resident #9 liked Resident #8 and she was not in a vegetative state where she could not say if the touching was unwanted or not. She said she did not see this incident as any type of abuse. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/2024 at 12:40 PM, the Regional Director of Operations said usually the Administrators would reach out to him for guidance to see if any incident needed to be reported or not. He said he reviewed the progress note for Resident #8 dated 12/30/2023 but did not have anything documented to show that the facility had reached out to him or not. He said there should have been a conversation about the incident, and it should have been reported to the state agency and reported within 2 hours. Record review of a facility policy titled Abuse, Neglect and Exploitation dated 10/24/2022 indicated, .It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written polices and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. VII. Reporting/Response: A. The facility reports abuse and abuse allegations that include: 2. Reporting of all alleged violations to the Administrator, state agency, within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the event that cause the allegation involve abuse . Record review of a facility policy titled Resident Rights-Sexual Activity dated 12/14/2016 indicated, .Sexual abuse is non-consensual sexual activity of any type with a residents .		

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NAME OF PROVIDER OR SUPPLIER Winfield Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1108 E Loop 304 Crockett, TX 75835	
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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339 Based on observation, interviews and record review, the facility failed to ensure the necessary treatment and services, in accordance with comprehensive assessment and professional standards of practice, to prevent development of pressure injuries was provided for 3 of 4 Residents (Resident #13, Resident #14 and Resident #15) reviewed for pressure injuries. The facility failed to implement interventions to prevent pressure ulcer or injury development for Resident #13 and Resident #14. The facility failed to provide ongoing skin assessments causing undiscovered wounds for Resident #13 and Resident #14 to go untreated. The facility failed to implement the wound care physicians' recommendations for Resident #13. The facility failed to identify and treat wound to Resident #13's right outer ankle. The facility failed to identify and treat wound to Resident #14's left heel. The facility failed to ensure preventative equipment was in working order for Resident #15 on 6/27/24 when Resident #15 was lying on a deflated low air loss mattress for an undetermined amount of time. An IJ was identified on 6/27/24 at 5:24 PM. The IJ template was provided to the facility on [DATE] at 5:24 PM. While the IJ was removed on 6/28/24 at 5:22 PM, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on pressure ulcer prevention and management. These failures could place residents at risk for new development or worsening of existing pressure injuries, pain, and decreased quality of life. Findings included: 1. Record review of the face sheet dated 6/26/24 indicated Resident #13 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including chronic kidney disease, diabetes, hypertension (elevated blood pressure), and congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should). (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the MDS dated [DATE] indicated Resident #13 usually understood others and was usually understood by others. The MDS indicated Resident #1 had a BIMS score of 0 and had severe cognitive impairment. The MDS indicated Resident #13 required substantial/maximum assistance with toileting hygiene, showering/bathing, moving from sitting to lying, and moving from lying to sitting on the side of the bed. The MDS indicated Resident #13 was dependent with transfers. The MDS indicated Resident #13 was at risk for developing pressure ulcers/injuries. The MDS indicated Resident #13 had 1 stage 4 (full thickness tissue loss with exposed bone, tendon or muscle. Slough (any yellowish material noted in the wound bed) or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. The MDS indicated the 1 stage 4 pressure ulcer was present upon admission to the facility. Record review of the care plan last revised on 6/9/24 indicated Resident #13 had a pressure ulcer and was at risk for infection, pain, and a decline in functional abilities with interventions that included: 1. Notify physician and responsible party of changes in status. 2. Provide wound care per physician's order. Keep dressing clean, dry, and intact. Replace the dressing as needed for soiling. 3. Monitor dressing to ensure it is intact and adhering. Report loose or soiled dressings to treatment or charge nurse. 4. Routinely evaluate and document the wound dimensions, drainage, and condition of surrounding tissue. Notify the physician as needed for changes. 5. Monitor and document for signs and symptoms of infection such as foul-smelling drainage, redness, swelling, tenderness, fever, and red lines or streaking originating at the wound. Notify the physician when detected. 6. Weekly skin checks to monitor for redness, circulatory problems, pressure sores, open areas, and other changes in skin integrity. Report new conditions to the physician. Record review of the physician orders dated 6/26/24 indicated Resident #13 had an order to: 1. left distal foot: cleanse wound with normal saline, pat dry, apply leptospermum honey, and alginate calcium, then cover with gauze island with border daily. 2. left lateral foot wound: cleanse with normal saline, apply betadine, and cover with gauze island with border daily. 3. left distal lateral foot wound: cleanse with normal saline, pat dry with gauze, apply betadine, leave open to air. 4. Right distal medial foot: cleanse with normal saline, pat dry, apply leptospermum honey, and alginate calcium, then secure with gauze island with border daily. 5. Perform head to toe skin assessment. Document any changes in skin integrity in the medical record. Every day shift every FRI for wound prevention/early identification notify the physician of any changes in skin integrity. Record review of Braden Scale for Predicting Pressure Sore Risk dated 5/23/24 revealed Resident #13's score of 17 which indicated Resident #13 was at low risk for developing a pressure sore. Record review of Braden Scale for Predicting Pressure Sore Risk dated 5/16/24 revealed Resident #13's score of 17 which indicated Resident #13 was at low risk for developing a pressure sore. Record review of Braden Scale for Predicting Pressure Sore Risk dated 5/9/24 revealed Resident #13's score of 14 which indicated Resident #13 was at moderate risk for developing a pressure sore. Record review of Braden Scale for Predicting Pressure Sore Risk dated 5/2/24 revealed Resident #13's score of 13 which indicated Resident #13 was at moderate risk for developing a pressure sore. Record review of Braden Scale for Predicting Pressure Sore Risk dated 4/19/24 revealed Resident #13's score of 13 which indicated Resident #13 was at moderate risk for developing a pressure sore. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the TAR for June 2024 indicated Resident #13 was scheduled to have wound care to his left distal medial foot (site 1), left lateral foot (site 3), left distal lateral foot (site 4), and right distal medial foot (site 5). Resident #13 had a physician's order to Perform head to toe skin assessment. Document any changes in skin integrity in the medical record. Every day shift every Fri for wound prevention/early identification notify the physician of any changes in skin integrity. The June TAR indicated the head-to-toe skin assessment had been completed on 6/20/24. Record review of Resident #13's clinical record revealed Resident #13 did not have a documented skin assessment with wound measurements or description of wound. Record review of Wound Evaluation & Management Summary completed by the wound care physician dated 6/3/24 indicated Resident #13 had: 1. Stage 4 pressure wound to the Left, Distal, Medial Foot Full Thickness measuring 1.1 x 1.2 x 0.1 centimeter. with recommendations to Float Heels in Bed; Pressure off-loading boot. 2. Unstageable of the Left, Lateral Foot Full Thickness measuring 1.8 x 1.5 x not measurable centimeters with recommendations to Reposition per facility protocol; float heels in bed; pressure off-loading boot; off-load wound. 3. Stage 3 pressure wound of the left, distal, lateral foot full thickness measuring 0.5 x 0.5 x not measurable centimeters with recommendations for Pressure off-loading boot; off-load wound; reposition per facility protocol. Record review of Wound Evaluation & Management Summary completed by the wound care physician dated 6/13/24 indicated Resident #13 had: 1. Stage 4 pressure wound to the Left, Distal, Medial Foot Full Thickness measuring 1.1 x 1.2 x 0.1 centimeter. with recommendations to Float Heels in Bed; Pressure off-loading boot. 2. Unstageable of the Left, Lateral Foot Full Thickness measuring 1.8 x 1.5 x not measurable centimeters with recommendations to Reposition per facility protocol; float heels in bed; pressure off-loading boot; off-load wound. 3. Stage 3 pressure wound of the left, distal, lateral foot full thickness measuring 0.5 x 0.5 x not measurable centimeters with recommendations for Pressure off-loading boot; off-load wound; reposition per facility protocol. Record review of Wound Evaluation & Management Summary completed by the wound care physician dated 6/19/24 indicated Resident #13 had: 1. Stage 4 pressure wound to the Left, Distal, Medial Foot Full Thickness measuring 0.8 x 0.7 x 0.1 centimeter. with recommendations to Float Heels in Bed; Pressure off-loading boot. 2. Unstageable of the Left, Lateral Foot Full Thickness measuring 0.8 x 0.7 x not measurable centimeters with recommendations to Reposition per facility protocol; float heels in bed; pressure off-loading boot; off-load wound. 3. Stage 4 pressure wound of the left, distal, lateral foot full thickness measuring 1.3 x 0.8 x not measurable centimeters with recommendations for Pressure off-loading boot; off-load wound; reposition per facility protocol. 4. Stage 4 pressure wound of the right, distal, medial foot full thickness measuring 1.5 x 1.5 x 0.3 with recommendations off-load wound; reposition per facility protocol; pressure off-loading boot. Investigations: Recommended And/Or Reviewed: Arterial Doppler Pending as of 6/19/2024. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Wound Evaluation & Management Summary completed by the wound care physician dated 6/26/24 indicated Resident #13 had: 1. Stage 4 pressure wound to the Left, Distal, Medial Foot Full Thickness measuring 0.8 x 0.7 x 0.1 centimeter. with recommendations to Float Heels in Bed; Pressure off-loading boot. 2. Unstageable of the Left, Lateral Foot Full Thickness measuring 0.8 x 0.7 x not measurable centimeters with recommendations to Reposition per facility protocol; float heels in bed; pressure off-loading boot; off-load wound. 3. Stage 4 pressure wound of the left, distal, lateral foot full thickness measuring 1.3 x 0.8 x 0.2 centimeters with recommendations for Pressure off-loading boot; off-load wound; reposition per facility protocol. 4. Stage 4 pressure wound of the right, distal, medial foot full thickness measuring 1.5 x 1.5 x not measurable centimeters with recommendations off-load wound; reposition per facility protocol; pressure off-loading boot. Record review of Wound Evaluation & Management Summary completed by the wound care physician dated 6/27/24 indicated Resident #13 had: 1. Stage 4 pressure wound to the Left, Distal, Medial Foot Full Thickness measuring 0.8 x 0.7 x 0.1 centimeter. with recommendations to Float Heels in Bed; Pressure off-loading boot. 2. Unstageable of the Left, Lateral Foot Full Thickness measuring 0.8 x 0.7 x not measurable centimeters with recommendations to Reposition per facility protocol; float heels in bed; pressure off-loading boot; off-load wound. 3. Stage 4 pressure wound of the left, distal, lateral foot full thickness measuring 1.3 x 0.8 x 0.2 centimeters with recommendations for Pressure off-loading boot; off-load wound; reposition per facility protocol. 4. Stage 4 pressure wound of the right, distal, medial foot full thickness measuring 1.5 x 1.5 x not measurable centimeters with recommendations off-load wound; reposition per facility protocol; pressure off-loading boot. 5. Arterial wound of the right, posterior ankle full thickness measuring 1.2 x 1.5 x not measurable centimeters Depth is unmeasurable due to presence of nonviable tissue and necrosis. With recommendations off-load wound; reposition per facility protocol; pressure off-loading boot. Record review of Resident #13's nursing progress notes dated 6/1/24 to 6/27/24 revealed Resident #13 did not have documentation of wound measurements, description of wounds, or weekly skin assessments. 2. Record review of face sheet dated 6/28/24 indicated Resident #14 was a [AGE] year-old male that admitted to the facility on [DATE] with the most recent admission of 5/15/24 with diagnoses that included: urinary tract infection (infection in the urine), pressure ulcer of sacral region stage 4, acquired absence of right leg above knee (right leg amputation above the knee). Record review of the MDS dated [DATE] indicated Resident #14 understood others and was understood by others. The MDS indicated Resident #14 had a BIMS score of 15 and was cognitively intact. The MDS indicated Resident #14 required substantial/maximum assistance with showering/bathing, tub/shower transfer, and lower body dressing. The MDS indicated Resident #14 required partial/moderate assistance for upper body dressing. The MDS indicated Resident #14 was dependent for putting on/taking off footwear. The MDS indicated Resident #14 required set up or clean up assistance with eating, personal hygiene, and oral hygiene. The MDS indicated Resident #14 was independent with rolling left and right, sit to lying, lying to sitting on side of bed, and chair/bed to chair transfer. The MDS indicated Resident #14 was at risk for developing pressure ulcers/injuries. The MDS indicated Resident #14 had 1 stage 4 (full thickness tissue loss with exposed bone, tendon or muscle. Slough (any yellowish material noted in the wound bed) or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. The MDS indicated the 1 stage 4 pressure ulcer was present upon admission to the facility. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the care plan last revised on 5/2/24 indicated Resident #14 had a pressure ulcer and was at risk for infection, pain, and a decline in functional abilities with interventions that included: 1. Notify physician and responsible party of changes in status. 2. Provide wound care per physician's order. Keep dressing clean, dry, and intact. Replace the dressing as needed for soiling. 3. Monitor dressing to ensure it is intact and adhering. Report loose or soiled dressings to treatment or charge nurse. 4. Routinely evaluate and document the wound dimensions, drainage, and condition of surrounding tissue. Notify the physician as needed for changes. 5. Monitor and document for signs and symptoms of infection such as foul-smelling drainage, redness, swelling, tenderness, fever, and red lines or streaking originating at the wound. Notify the physician when detected. 6. Weekly skin checks to monitor for redness, circulatory problems, pressure sores, open areas, and other changes in skin integrity. Report new conditions to the physician. 7. Pressure relieving/reducing devices on bed/chair. 8. Low air loss mattress. Record review of the physician orders dated 6/28/24 indicated Resident #14 had an order to: 1. (site 14) Skin tear wound of the left ischium: cleanse with normal saline, pat dry, apply leptospermum honey then cover with gauze island with border daily. 2. (skin 1) Sacrum wound: Cleanse wound with normal saline, pat dry, with gauze, apply collagen sheet to wound bed, then negative pressure wound therapy on Monday, Wednesday, and Friday weekly. Record review of Resident #14's nurse progress notes dated 6/1/24 through 6/27/24 revealed no documentation of weekly skin assessment or wound assessment with updated measurements, description of wound, or treatment order. Record review of Braden Scale for Predicting Pressure Sore Risk dated 6/5/24 revealed Resident #14's score of 20 which indicated Resident #14 was not at risk for developing a pressure sore. Record review of Braden Scale for Predicting Pressure Sore Risk dated 5/29/24 revealed Resident #14's score of 20 which indicated Resident #14 was not at risk for developing a pressure sore. Record review of Braden Scale for Predicting Pressure Sore Risk dated 5/22/24 revealed Resident #14's score of 20 which indicated Resident #14 was not at risk for developing a pressure sore. Record review of Braden Scale for Predicting Pressure Sore Risk dated 5/15/24 revealed Resident #14's score of 17 which indicated Resident #14 was at low risk for developing a pressure sore. Record review of Braden Scale for Predicting Pressure Sore Risk dated 4/10/24 revealed Resident #14's score of 14 which indicated Resident #14 was at moderate risk for developing a pressure sore. Record review of Record review of Wound Evaluation & Management Summary completed by the wound care physician dated 6/3/24 indicated Resident #14 had: 1. Stage 4 pressure wound sacrum full thickness measuring 1.6 x 0.6 x 0.4 centimeters with recommendations of limit sitting to 60 minutes; upgrade offloading chair cushion; reposition per facility protocol; low air loss mattress; off-load wound. 2. Skin tear wound of the left ischium full thickness measuring 1.2 x 0.6 x not measurable centimeters with recommendations of reposition per facility protocol; off-load wound. Record review of Wound Evaluation & Management Summary completed by the wound care physician dated 6/13/24 indicated Resident #14 was not seen by the wound care doctor due to declined to be seen because he has to go smoke. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Record review of Wound Evaluation & Management Summary completed by the wound care physician dated 6/19/24 indicated Resident #14 had: 1. Stage 4 pressure wound sacrum full thickness measuring 1.6 x 0.5 x 0.4 centimeters with recommendations of limit sitting to 60 minutes; upgrade offloading chair cushion; reposition per facility protocol; low air loss mattress; off-load wound. 2. Skin tear wound of the left ischium full thickness measuring 1.0 x 0.6 x 0.1 centimeters with recommendations of reposition per facility protocol; off-load wound. Record review of Wound Evaluation & Management Summary completed by the wound care physician dated 6/26/24 indicated Resident #14 had: 1. Stage 4 pressure wound sacrum full thickness measuring 1.3 x 0.5 x 0.4 centimeters with recommendations of limit sitting to 60 minutes; upgrade offloading chair cushion; reposition per facility protocol; low air loss mattress; off-load wound. 2. Skin tear wound of the left ischium full thickness measuring 1.0 x 0.6 x 0.1 centimeters with recommendations of reposition per facility protocol; off-load wound. Record review of Wound Evaluation & Management Summary completed by the wound care physician dated 6/27/24 indicated Resident #14 had: 1. Stage 4 pressure wound sacrum full thickness measuring 1.3 x 0.5 x 0.4 centimeters with recommendations of limit sitting to 60 minutes; upgrade offloading chair cushion; reposition per facility protocol; low air loss mattress; off-load wound. 2. Skin tear wound of the left ischium full thickness measuring 1.0 x 0.6 x 0.1 centimeters with recommendations of reposition per facility protocol; off-load wound. 3. non-pressure wound of the left heel undetermined thickness measuring 0.5 x 1.2 x not measurable centimeters with recommendation to pad the wheelchair. 3. Record review of the face sheet dated 6/28/24 indicated Resident #15 was an [AGE] year-old male admitted to the facility on [DATE] with the most recent admission on 4/4/24 with diagnoses including severe protein calorie malnutrition (nutritional status in which reduced availability of nutrients leads to changes in body composition and function), pressure ulcer of left heel, unstageable, muscle weakness, and abnormal weight loss. Record review of the MDS dated [DATE] indicated Resident #15 understood others and was understood by others. The MDS indicated Resident #15 had a BIMS score of 0 and had severe cognitive impairment. The MDS indicated Resident #15 required substantial/maximum assistance with rolling left and right, moving from sitting to lying, and moving from lying to sitting on the side of the bed. The MDS indicated Resident #15 was partial/moderate assist with eating, oral hygiene, toileting hygiene, shower/bathing, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident #15 was dependent with transfers. The MDS indicated Resident #15 was at risk for developing pressure ulcers/injuries. The MDS indicated Resident #15 had 1 unstageable (slough and/or eschar: known by not stageable due to coverage of wound bed by slough and/or eschar). The MDS indicated the 1 unstageable pressure ulcer was present upon admission to the facility. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the care plan last revised on 3/11/24 indicated Resident #15 had an unstageable pressure ulcer to his left heel and was at risk for infection, pain, and a decline in functional abilities with interventions that included: 1. Notify physician and responsible party of changes in status. 2. Provide wound care per physician's order. Keep dressing clean, dry, and intact. Replace the dressing as needed for soiling. 3. Monitor dressing to ensure it is intact and adhering. Report loose or soiled dressings to treatment or charge nurse. 4. Routinely evaluate and document the wound dimensions, drainage, and condition of surrounding tissue. Notify the physician as needed for changes. 5. Monitor and document for signs and symptoms of infection such as foul-smelling drainage, redness, swelling, tenderness, fever, and red lines or streaking originating at the wound. Notify the physician when detected. 6. Weekly skin checks to monitor for redness, circulatory problems, pressure sores, open areas, and other changes in skin integrity. Report new conditions to the physician. Record review of the physician orders dated 6/28/24 indicated Resident #15 had an order to: (site 1) left heel wound: cleanse with normal saline gauze, pat dry, apply leptospermum honey, then cover non-sterile gauze, secure with gauze island with border daily. Record review of Resident #15's nurse progress notes dated 6/1/24 through 6/27/24 revealed no documentation of weekly skin assessment or wound assessment with updated measurements, description of wound, or treatment order. Record review of Braden Scale for Predicting Pressure Sore Risk dated 4/28/24 revealed Resident #15's score of 12 which indicated Resident #15 was at high risk for developing a pressure sore. Record review of Braden Scale for Predicting Pressure Sore Risk dated 4/21/24 revealed Resident #15's score of 12 which indicated Resident #15 was at high risk for developing a pressure sore. Record review of Braden Scale for Predicting Pressure Sore Risk dated 4/18/24 revealed Resident #15's score of 12 which indicated Resident #15 was at high risk for developing a pressure sore. Record review of Braden Scale for Predicting Pressure Sore Risk dated 4/11/24 revealed Resident #15's score of 14 which indicated Resident #15 was at moderate risk for developing a pressure sore. Record review of Braden Scale for Predicting Pressure Sore Risk dated 4/4/24 revealed Resident #15's score of 12 which indicated Resident #15 was at high risk for developing a pressure sore. Record review of Record review of Wound Evaluation & Management Summary completed by the wound care physician dated 6/3/24 indicated Resident #15 had: 1. Stage 4 pressure wound of the left heel full thickness measuring 2.3 x 2.3 x 0.2 centimeters with recommendations to reposition per facility protocol; float heels in bed; pressure off-loading boot; off-load wound. Record review of Record review of Wound Evaluation & Management Summary completed by the wound care physician dated 6/13/24 indicated Resident #15 had: 1. Stage 4 pressure wound of the left heel full thickness measuring 2.3 x 2.3 x 0.2 centimeters with recommendations to reposition per facility protocol; float heels in bed; pressure off-loading boot; off-load wound. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Record review of Wound Evaluation & Management Summary completed by the wound care physician dated 6/19/24 indicated Resident #15 had: 1. Stage 4 pressure wound of the left heel full thickness measuring 2.3 x 2.3 x 0.2 centimeters with recommendations to reposition per facility protocol; float heels in bed; pressure off-loading boot; off-load wound. Record review of Record review of Wound Evaluation & Management Summary completed by the wound care physician dated 6/26/24 indicated Resident #15 had: 1. Stage 4 pressure wound of the left heel full thickness measuring 2.1 x 2.0 x 0.2 centimeters with recommendations to reposition per facility protocol; float heels in bed; pressure off-loading boot; off-load wound. During an interview and observation on 6/24/24 at 10:33 AM Resident #13 was lying in bed awake and alert with bilateral feet uncovered with bilateral feet not floated, and no dressing to the left distal medial foot or the left lateral foot. Resident #13 did not have feet off loaded or pressure off loading boots in place. Resident #13 did not have a low air loss mattress on his bed. Resident #13 was not able to answer questions appropriately due to cognition. During an interview on 6/27/24 at 9:17 AM the Regional Nurse Consultant HH said weekly skin assessments were signed off on in the ETAR and documented in a nurse progress note that they were completed. She said if a wound was identified then it was documented in a system called Gentell and in a progress note. She said the wound care physician usually came to the facility on ce a week and documents on a wound evaluation and management summary note and if needed a nurse from Gentell comes to the facility to see the residents. She said if it was a wound that does not require the wound care doctor or the Gentell nurse then it would be documented in the progress notes in the medical record. During an observation on 6/27/24 at 11:01 AM of wound care provided by the Treatment Nurse and LVN DD, on Resident #13 sitting in geri chair to bilateral feet, resident had on gripper socks with no other preventative measures in place. Wounds observed were: stage 4 pressure ulcer of lateral medial left foot, Stage 3 of left lateral distal foot, unstageable of left lateral foot, and stage 4 right distal medial foot. Also observed undocumented wound to the right posterior ankle open with thick adherent black necrotic tissue (eschar) in the center measuring 1.2cm x 1.5cm x not measurable due to eschar with light serous exudate with no treatment applied. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 6/27/24 at 11:01 AM the Treatment Nurse said he had worked at the facility PRN for about 2 years, he said he performs wound care Monday through Friday for the last 2 years but was not full time. He said he and LVN DD were responsible for completing weekly skin assessments. He said he signs off the TAR for the weekly skin assessments but does not document the skin assessment anywhere else. He said the wound care doctor comes in once a week usually on Wednesdays and sees all pressure wounds in the facility. He said the next day after the wound care doctor came, LVN DD enters the new orders in the medical record and documents the wound assessment from the wound care doctor into the Gentell report. The Treatment Nurse said he did not measure any wounds in the building, he said the wound care doctor is the only person that measures wounds that he is aware of. He said if he did a skin assessment that revealed a new wound, he would usually text the wound care doctor for orders. He said he would sometimes let the charge nurse know of a new wound but the charge nurse did not notify the family or the doctor of the wound. He said he did not document the wound anywhere else and did not measure the wound. He said the next time the wound care doctor was in the facility he would see the resident and determine the type of wound, measure the wound, and document the description of the wound on the Wound Evaluation & Management Summary. The Treatment Nurse said he did not do any other documentation on the wound except enter the new order for wound care. He said he did not notify the families of any new wounds or updates on existing wounds. He said Resident #13 had seen the wound care doctor the day before and did not know how the wound care doctor had missed the new undocumented wound to his right posterior ankle. He said he would notify the doctor and get new orders to treat the new wound. When surveyor asked if anyone assessed wounds or documented wound measurements between 6/3/24 and 6/13/24 when the wound care doctor did not come, he said no one. During an interview on 6/27/24 at 11:01 AM LVN DD said she had worked at the facility as needed usually on Wednesdays when the wound care doctor came in and the day after the wound care doctor came to the facility. She said she enters in all new orders from the wound care doctor the following day after he made rounds. She said she enters the information from the wound care doctor on the Gentell report. She said weekly skin assessments were signed off on the TAR but there was no other documentation that they do. She said the wound care doctor measures all pressure wounds weekly when he comes, and the Treatment Nurse does not measure the wounds. She said she only does wound care if the Treatment Nurse wanted a day off. She said Resident #13 rubbed his feet back and forth a lot and if they put pillows under his feet Resident #13 would usually kick them around. She said she had never seen a pressure relieving boot for Resident #13. During an observation and interview on 6/27/24 at 2:40 PM Resident #14 was observed sitting up in a wheelchair in his room, awake and alert. Resident #14 had a above the knee right leg amputation. Resident #14's left leg was discolored with redness and purple blueish color below the knee and foot. He said on his left heel he had a spot that the wheelchair peg had rubbed, and it had been there for about 1 1/2 years. Observed an undocumented dime size spot that was not open but has a brown scab like area that was hard to the left heel with dry skin surrounding the area. He said he had a rash in the peri area that the night aide usually puts a cream on. Observed residents' bed was a low air loss mattress. Observed black rolled up sock to Resident 14's left wheelchair footrest. Resident #14 said he rolled up a sock and rubber banded it to the footrest of his wheelchair to keep the peg from rubbing on his left heel. Resident #14 said the facility staff had not treated or looked at his left foot. Resident #14 said no one ever came in to assess his skin. He said once a week or every other week the wound care doctor came in and looked at his buttocks for about 2 minutes and leaves but did not ever look at any other part of his skin. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Winfield Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1108 E Loop 304 Crockett, TX 75835	
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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on 6/27/24 at 2:52 PM Resident #15 was observed lying in bed awake and alert. Resident #15 had a dressing to the left heel dated 6/27/24. Resident #15 was observed laying on a deflated low air loss mattress in his room. Upon further inspection it was determined that resident's bed frame was able to be felt due to resident's low air loss mattress being deflated. Resident #15 said he did not know for how long the mattress had been deflated. When surveyor asked Resident #15 if he was having any pain at that time Resident #15 responded yes. Resident #15 was not able to tell where the pain was or how long he had the pain. During an observation and interview on 6/27/24 at 2:52 PM The Wound Care Consultant said she had come to the facility on [DATE] at the request of the facility. She said if the facility needed advice on a wound she would come to the facility if they requested her to. She said she did not normally come to the facility very often. Upon the request of the surveyor, the Wound Care Consultant observed Resident #14's left heel wound and said in her opinion Resident #14's left heel wound was an arterial wound (painful, deep sore or wound that doesn't heal due to decrease blood flow to the area). She said she would order betadine to the wound daily and at the least the wound should be monitored daily. The Wound Care Consultant observed Resident #15's low air loss mattress to be deflated on 6/27/24 at 2:52 PM and said with Resident #15's air mattress being flat it was not providing pressure relief for Resident #15. The Wound Care Consultant said the purpose of the low air loss mattress was for pressure relief of boney prominences of a resident that was at risk for skin breakdown or that had skin breakdown. The Wound Care Consultant said lying on a deflated low air loss mattress could cause further deterioration of Resident #15's skin. The Wound Care Consultant did not assess Resident #15 [TRUNCATED]		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 43994 Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for 1 of 14 residents (Resident #12) reviewed for accidents. The facility failed to properly secure Resident #12 during transport in the facility van on 3/2/2024 when he fell out of his wheelchair into the facility van. On 4/4/2024 his wheelchair lifted off the floor from defective floor straps. An Immediate Jeopardy (IJ) situation was identified on 6/26/2024 at 2:40 PM. While the IJ was removed on 6/27/2024 at 1:35 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of their corrective systems. This failure could place residents at risk for serious injury and accidents. Findings included: Record review of an Admission Record for Resident #12 dated 6/26/2024 indicated he admitted to the facility on [DATE] and was discharged on [DATE]. He was [AGE] years old with diagnoses of type 2 diabetes, orthopedic after following surgical amputation (surgery after following removal of a bone), acquired absence of left leg above the knee (surgical removal of the left leg above the knee), hypertension, and end stage renal disease (kidney failure). Record review of a Quarterly MDS Assessment for Resident #12 dated 4/25/2024 indicated he had moderate impairment in thinking with a BIMS score of 12. He required partial/moderate assistance to supervision with ADL's and used a wheelchair for mobility. He had two falls since admission with no injury and 1 fall with injury. Special Treatment, Procedures, and Programs while a resident included dialysis during the 14 day look back period. Record review of a care plan for Resident #12 revised on 6/24/2024 indicated he had an ADL self-care performance deficit with interventions of wheelchair independent. He has the potential for falls related to incontinence, gait/balance problems with interventions to educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Record review of an incident report for Resident #12 dated 3/2/2024 by RN FF indicated, Resident slide out of wheelchair per transport driver. Dressing change completed to left BKA due to dressing saturated with serosanguineous fluid (thin, watery fluid). Resident assessed for any other injuries at this time. Resident asked if he was having pain, resident denied. Resident not taken to the hospital. No injuries observed at time of incident. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of an incident report for Resident #12 dated 4/4/2024 by RN FF indicated, 1430 (2:30 PM) was reported to this nurse that this resident en route back to the facility fell backwards in the transportation van est. time 1225 (12:25 PM). When resident arrives to facility, resident to have assessment performed. 1535 (3:35 PM) Resident to facility. Resident received in wheelchair taken to room. Resident AAOx's 4, no new raised areas on back of head no injuries noted, resident denied hitting back of head and/or LOC. No N/V, no dizziness, no blurry vision, [NAME] well, resp. even and unlabored. Abd soft with positive bowel sounds. Resident informed resident that should he have N/V, dizziness, any changes in vision. He is to let nursing staff be aware. No injuries observed at time of incident. Not taken the hospital. He was oriented to person, place, and time. During a phone interview on 6/25/2024 at 9:13 PM, RN FF said she had been employed at the facility for 2 years and was full time on the 6a-6p shift and worked halls 200 and 300. She said Resident #12 was discharged to the hospital after an appointment. She said some time back in April 2024, she was working and was called to go outside of the facility by CNA C who was the driver of the van. She said CNA C entered the facility and told her Resident #12 had fallen in the van. She said she went outside and asked him if he was hurt and if he had hit his head, she said he denied hitting his head, but did fall on his knee. She said his wheelchair was present. She said he told her he just went down on his knee and was not complaining of anything at that time. She said CNA C took him to dialysis and she notified dialysis of the fall. She said later on she had heard he had fallen another time. During an interview on 6/26/2024 at 8:22 AM, ADON D said she had been employed at the facility for 3 years. She said she was responsible for scheduling the resident's appointments. She said she scheduled the appointments for the residents and placed them on the calendar and then scheduled the transportation. She said some of their residents were Medicaid transports and they received transportation from an outside company. She said Resident #12 admitted in January 2024 and initially was transported to dialysis via the facility van and his dialysis days were Tuesday, Thursday, and Saturday. She said they stopped sometime in mid-February providing transport to dialysis and then began with an outside company for transport. She said the Transport Aide and CNA C were the staff assigned to provide transport. She said CNA C had not been assigned transport in quite some time since February 2024. She said she was aware of the incidents with Resident #12 where he fell out of his wheelchair during transport in the facility van. She said if the transport were local then there would only be the driver, if longer distance then they would send two people for the transport. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/26/2024 at 8:39 AM, CNA C said she had been employed at the facility for 2 years, currently was on back up for transport and started driving in January 2024. She said she was involved with one of the 2 incidents with Resident #12. She said the incident involved transport in the facility van. She said Resident #12 was loaded in the van and they were driving through the parking lot, she felt something warm on her leg and got on the brakes, stopped the van, looked back and saw that Resident #12 was on the floor of the van down on one knee. She said she got out to check on him, backed the van up and came inside and got the nurses. She said the nurses came outside, picked him up and placed him back in his chair She said the nurse rewrapped his leg which had been leaking from the night before and they proceeded to go to dialysis. She said on the way, Resident #12said he was not feeling well and did not want to go and they went to the facility. She said the Transport Aide taught her how to load residents into the van and basically went by a checklist for transports. She said Maintenance at that time went over the skills and checked her off, but no longer worked at the facility. She said following the incidents they had in-services on safety and protocols with using the safety harnesses. She said she did not use the safety harnesses during the transport of Resident #12. She said she was trained on using the safety harness-lap belt but said Resident #12 did not want to wear it. She said she would drive slowly to ensure he did not fall. She said he did not want to wear the seat belt. She said before scheduled transports, she only checked the mileage and did not do any type of inspection of the van and was not sure if she had to do any type of inspection before transports. During an observation and interview on 6/26/2024 at 8:58 AM, CNA C was observed showing the facility van to the State Surveyor in the back parking lot. She said the facility van was out of service and needed repairs on the wheelchair ramp lift. She said there was one strap for the ramp that was placed at the back of the wheelchair, no lap belt, said it never had a lap belt. Inside the van, she demonstrated how the floor harness connected to the seat belt across their lap. She said Resident #12 did not want the lap belt across him during transport. Record review of a disciplinary memorandum for CNA C dated 3/4/2024 by the Administrator indicated a formal written disciplinary action that indicated anytime driving a resident, must be secured, if they refuse to be secured by the seatbelt, the resident will not be transported. Record review of a checklist for community driver van-bus for CNA C dated 12/27/2023 indicated she demonstrated competency on safe transfers and application of seat belt. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/26/2024 at 9:20 AM, the Transport Aide said she had been employed at the facility for a year and was full time as the transport driver. She said there was an incident that occurred in April 2024 while she transported Resident #12 to a doctor's appointment out of town on the way back. She said they used the facility van for transport that day. She said they were leaving a doctor appointment and headed back. She said she was at a stop light, and it turned green and went to turn and Resident #12 was heard saying whoa whoa whoa, put on the hazard lights, and noticed that his wheelchair was leaning backwards. She said he was still strapped by the wheels, and she had RA with her to help check on him and said everything was still locked. She said she parked, and they both checked on him and unstrapped him and re-strapped. She said she called the DON to inform her about what happened and about 5-10 minutes later, the Administrator called and asked how he was leaning backwards if he was strapped. She said they arrived back to the facility, met with the Maintenance Supervisor, and went to check the straps in the van and started realizing that some of the straps were worn. She said the straps when in the locked position, if pulled hard enough would release. She said they found a total of four that were worn, and they were ordered the same day. She said Resident #12 never fell out of his wheelchair. She said she received training by the previous Maintenance Supervisor initially but had not had one since then. She said the straps she chose to check that day were ok, but she did not check all the straps that morning before they left and only checked the ones she was using. She said following the incident, she had an in-service on the safety of the straps and had one previously with another incident. She said she would check with the Maintenance Supervisor to see if he had a copy of the manufacturer's guidelines for the straps. Record review of an orientation checklist for community driver van-bus for the Transport Aide dated 12/23/2021 indicated she was able to work all securement properly. Request for the manufacturer's guidelines for the straps in the van by the Transport Aide and none was provided. During an observation and interview on 6/26/2024 at 10:00 AM, the Transport Aide said the facility was not using a rental wheelchair accessible van for transports as of Friday 6/21/2024 because of issues with the lift. She provided a return demonstration with a staff member in a wheelchair on how to properly load into the van: she demonstrated the proper way to load, secure and unload safely. She said the rental company did not show the staff how to properly secure a resident into the rental van. She said if a new van driver were hired, the Maintenance Supervisor would do a check off with them. During an observation and interview on 6/26/2024 at 10:10 AM, the Maintenance Supervisor was outside in the back parking lot where the facility van was located. He said he had been employed at the facility for 3 months. He said he was not sure who would train new drivers at the facility, and he had never been trained at the facility since being employed for van safety. He said he was not sure who would do it. He said he conducted a monthly check of the van of the tires and oil, but the mechanics inside of the vehicle he did not check. He said if there was a problem with the lift, they would send it out for repairs. He demonstrated how to load a wheelchair in the van, backed it onto the ramp and positioned the wheelchair in the van with the front of the wheelchair facing the side door entrance. He secured the wheelchair by the back wheels and the front wheels. He had difficulty securing the seat belt around the wheelchair where a resident would be positioned. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/26/2024 at 10:20 AM, the Regional Director of Operations said most likely the Maintenance Supervisor would be the person responsible for training a new person hired for transport for the facility. Attempted a phone interview on 6/26/2024 at 11:00 AM with Resident #12, voicemail box was full and was unable to leave a message. During a phone interview on 6/26/2024 at 11:07 AM, the Wheelchair Rental Van representative said when the rental van was dropped on 6/21/2204, no training was provided to the facility staff on how to properly secure a wheelchair in the van or how to use the ramp. He said the facility was responsible for ensuring their staff were trained. He said he would assume that the facility would train their staff and all of their vans had q-strains (wheelchair securement system) and shoulder seat belts inside of the vehicles for safety. During an interview on 7/1/2024 at 1:31 PM, the Administrator said she had been employed at the facility for 6 1/2 years. She said the transport drivers were responsible for ensuring the residents were secure and wore safety belts. She said the Maintenance Supervisor had a list for the drivers to check the overall function of the van. She said she was unaware that the drivers were not using the checklist. She said the facility van was out of service because the lift mechanism was not working properly and had been out of service for about 4 weeks. She said they had used the facility next door van and last week rented a van and used an outside transport company for the residents. She said currently the facility was not transporting anyone because the rental had some issues, and they were having to change to a different one because there were some straps that did not work. She said Maintenance should be doing a check of the van monthly or weekly. She said the Maintenance Supervisor received an in-service. She said if a resident refused to wear a seat belt, then the driver should refuse to take them and report it to her. She said there was a risk for resident safety if residents were not properly secured in the van. Record review of a facility policy titled Transportation Policy and Procedure for Facility Based Vehicle (Van) revised 3/13 indicated, .In order for our residents to maintain the highest practical, physical, mental and psychosocial well being it is the policy of this facility to utilize the Facility vehicle (van) for residents who because of medical or special needs, require transportation. Driver Responsibilities: d. Maintain the cleanliness of the vehicle and assure that the vehicle is in good repair and in full compliance with all recommended maintenance as per vehicle operating manual. e. Maintain a current log notebook to include: 1. Vehicle maintenance log, which will include but not limited to, a recommended routine maintenance as per the vehicle's operating manual. 3. Vehicle utilization log, which will include for each use if the vehicle; the date, the driver's name, the mileage at the beginning and end of use, purpose and destination of use, and the initials of the facility Administrator authorizing the use. F. Complete daily facility-based vehicle maintenance log and follow instructions accordingly. G. Keep a copy of this transportation policy and Procedure in the vehicle at all times. H. Must call 911 immediately should a resident become unresponsive or sustain a fall. Record review of facility in-service for March and April 2024 did not indicate a training was provided to any staff in the facility on safety during transport. Record review of the weekly vehicle maintenance logs for the facility van indicated no weekly log since 2022. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This was determined to be an Immediate Jeopardy (IJ) on 6/26/2024 at 2:40 PM. The facility's Regional Director of Operations, Regional Nurse Consultant JJ, Regional Nurse Consultant HH and DON were notified. The Regional Director of Operations was provided the IJ template on 6/26/2024 at 3:12 PM. The following Plan of Removal (POR) submitted by the facility was accepted on 6/27/2024 at 10:46 AM. Plan of Removal - F 689 Free of Accidents and Hazards/supervision/devices Tag Cited: F-689 Issue Cited: Free of Accidents/Hazards/Supervision Failure to in-Service staff on safety precautions during transport and the use of seat belts. 1. Immediate Action Taken A. Resident # 12 is currently out of the facility on 6/20/2024 B. The facility's van immediately stopped all van transport on 6/26/2024 at 8:00am C. The Regional Director of Operations or designee completed the following with the three facilities designated van drivers: - o In-service education on the Transportation Policy which provides direction on duties of driver, driving of the van, how to operate the wheelchair lift and the wheelchair securement system, how to transport more than 1 wheelchair - o In-service education on weekly maintenance log that van drivers complete and provides to administrator/designee - o Completed a skills validation check list on van drivers to acknowledge skills competence on how to operate the wheelchair lift and the wheelchair securement system. Completed a return demonstration. - o All van drivers sign job description duties - o Facility will decline transport to any resident who refuses to comply with Texas laws to wear a seat belt. The expectation is that all residents riding in facility van will wear a seat belt and have proper wheelchair securement if applicable. Facility will assist with alternate methods of transportation (ambulance, community ride and share vans, family members etc.) This was completed on 6/27/2024. 2. Identification of Residents Affected or Likely to be Affected: (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A. No other residents identified, all scheduled van transports for the remainder of the week will be transported by an outside vendor. This will allow the facility time for training all van drivers, complete skills competencies and return demonstration, with all van drivers. 3.Actions to Prevent Occurrence/Recurrence: A. As of 6/26/2024, any staff member hired for van transports will be provided the following by the facility maintenance supervisor - o In-service education on the Transportation Policy which provides direction on duties of driver, driving of the van, how to operate the wheelchair lift and the wheelchair securement system, how to transport more than 1 wheelchair prior to driving the van - o In-service education on weekly maintenance log that van driver completes and provides to administrator/designee - o Completed a skills validation check list on van driver to acknowledge skills competence on how to operate the wheelchair lift and the wheelchair securement system. Completed a return demonstration. - o Have van driver sign job description duties - o Understand that in the event a resident refuse to wear a seatbelt or have wheelchair securement if applicable, that the administrator or designee will be notified immediately to schedule alternate transportation - o Understand, that in the event of an emergency, pull over immediately as soon as it is safe to do so and call 911which is stated in the facility's Van Transportation policy B. The weekly maintenance log will be reviewed in the morning meeting by the Administrator or designee On 6/26/2024 the facility's Administrator notified the Medical Director regarding the Immediate Jeopardy the facility received related to Accidents/Hazards/Supervision and reviewed plan to sustain compliance Surveyors monitored the Plan of Removal as follows: Record review of the Admission Record for Resident #12 indicated he discharged from the facility on 6/20/2024. Record review of a Weekly Vehicle Maintenance Log dated 6/26/2024 by the Maintenance Supervisor and Regional Director of Operation for the rental van indicated the van was out of service for two straps not working, to be returned. Record review of an in-service on the Transportation Policy dated 6/26/2024 indicated training was provided to the Transport Aide, CNA C, and the Maintenance Supervisor. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of an in-service on the weekly vehicle maintenance log dated 6/26/2024 indicated training was provided to the Transport Aide, CNA C, and the Maintenance Supervisor. Record review of an orientation checklist for community driver dated 6/26/2024 indicated the Transport Aide, CNA C and the Maintenance Supervisor had a skills validation check off with return demonstration. Record review of a signed van drivers job description duties dated 6/26/2024 indicated training was provided to CNA C, the Transport Aide, and the Maintenance Supervisor. Record review of an in-service on declining transport for any resident who refuses to comply with Texas laws to wear a seat belt dated 6/26/2024 indicated training was provided to CNA C, the Transport Aide, and the Maintenance Supervisor. Record review of an appointment reminder for Resident #16 indicated he had an appointment scheduled for 6/27/2024 and the facility would contact EMS for transport. Record review of an appointment reminder dated 6/28/2024 and 6/29/2024 indicated no transports were scheduled. Record review of an appointment reminder for Resident #12 indicated he had an appointment scheduled for 7/1/2024 but was in the hospital. Record review of an appointment reminder for Resident #17 indicated she had an appointment scheduled for 7/1/2024 and the transport was scheduled with a contract transport company. Record review of an appointment reminder for Resident #18 indicated she had an appointment scheduled for 7/2/2024 and the transport was scheduled with a contract transport company. Record review of an in-service on in the event of an emergency dated 6/27/2024 indicated training was provided to CNA C, the Transport Aide, and the Maintenance Supervisor. Record review of an AdHoc QAPI dated 6/26/2024 indicated the Regional Nurse Consultant JJ, Regional Director of Operations, Regional Nurse Consultant HH, DON and the Medical Director were in attendance. Interviews on 6/27/2024 from 1:09 PM to 1:19 PM included: CNA C Transport Aide Maintenance Supervisor (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Winfield Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1108 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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/27/2024 at 1:09 PM, CNA C said she received in-service training on their job descriptions as a van driver, safety precautions, how to properly put on seatbelts, check straps, driving and maintenance logs, and loading onto ramp and lift. She said she had skills check off on 6/26/2024. She said if a resident refused to wear a seatbelt, then they were not able to transport as it was against the law to not wear one and let the resident know they would not be able to transport them. She said in the event of an emergency, dial 911. During an interview on 6/27/2024 at 1:13 PM, the Transport Aide said she had in-service training and went over job duties, how to load, unload, basic necessities in the van, and emergency precautions during transport. She said she had skills check off on 6/26/2024. She said if a resident refuses to wear a seatbelt, let them know they cannot transport, and in the event of an emergency pull over and call 911, then call to the facility. She said they were currently not using the van as of 6/26/2024 and they have arranged alternate transport for residents scheduled. She said they discussed their job descriptions and to have necessities on the van for the resident. During an interview on 6/27/2024 at 1:19 PM, the Maintenance Supervisor said he had in-service training and discussed how to secure a resident in the van, where to put seat belts, and how to secure wheelchairs. He said if a resident refused to wear a seatbelt, then they do not go anywhere. He said to check maintenance logs weekly and when they were transporting take them snacks, blankets and etc. He said in the event of an emergency pull over and call 911. He said he had a skills check off on 6/26/2024. He said the van was currently out of service because they found two straps that were defective as of 6/26/2024. All above staff were able to appropriately answer questions. The Regional Nurse Consultant JJ was informed the Immediate Jeopardy was removed on 6/27/2024 at 1:35 PM; however, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.		

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observations, interviews, and record reviews the facility failed to ensure 6 of 11 (NA H, NA K, NA L, NA M, NA O, NA P) staff were not working in the facility longer than four months without having completed a nurse aide competency evaluation program. The facility failed to ensure NA H, NA K, NA L, NA M, NA O, NA P became certified within four months of hire as full-time staff. This deficient practice place residents at risk for receiving care from an individual whose skill level was not known. The findings included: Record review of the facility staff roster provided upon entrance undated indicated the following staff were listed as nursing staff/trainee with hire dates: *Nurse Aide H hire date of 7/14/2023. *Nurse Aide K hire date of 7/14/2023. *Nurse Aide L hire date of 8/28/2023. *Nurse Aide M a hire date of 8/25/2023. *Nurse Aide O a hire date of 10/14/2023. *Nurse Aide P a hire date of 1/25/2024. Record review of employee personnel files indicated the following staff had not completed a training and competency evaluation program, or a competency evaluation program approved by the State: *Nurse Aide H *Nurse Aide K *Nurse Aide L *Nurse Aide L *Nurse Aide M *Nurse Aide O *Nurse Aide P (continued on next page)		

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 6/27/2024 at 8:29 AM, NA L was assigned to work on hall 400. She said she had been employed at the facility for over a year as a hospitality aide and been assigned as an aide on the floor for 9 months. She said she was not certified as a nurse aide. She was to answer the call light for residents on the hall and assisted them with choosing meal options from the menu. She lowered the head of the bed for the resident. She said she was assigned to work on hall 400 and there was only one aide assigned to each hall. She said she was responsible for providing all ADL care to the residents on her hall. She answered the call light for a resident in room [ROOM NUMBER], assisted her with choosing meal options from the menu from the kitchen and lowered the head of the bed for the resident. She said she logged into TULIP once a few months ago and had not completed a skills test or written test to become certified. She said when she first started on the floor, ADON Q taught her how to shave, bathe, brush teeth and etc. She said she did not have a test date scheduled to become certified. Record review of the staffing schedule dated 6/27/2024 indicated NA L was assigned to work hall 400 and had initialed by her name for the shift. During an interview on 6/28/2024 at 11:15 AM, ADON Q said she, the DON, and ADON D were responsible for staffing. She said HR was keeping up with the online training portions for the staff in the facility and the non-certified nurse aides. She said before the staff can test, they had to have 24 hours of continuing education and then that information was submitted into the TULIP portal. She said they had an extension to get them certified until the end of April 2024. She said she just heard that they had until the end of June 2024. She said they currently had 6 staff in the facility that were classified as hospitality aides, and they were non-certified which included NA H, NA K, NA L, NA M, NA O and NA P. She said she oversaw to make sure they had their 24 hours and then would schedule them to take the written and skills test. She said there was not anyone that checked to make sure those staff were getting the trainings required but she tried to check weekly as she could. She said she did not have any documentation to show the audits on where she checked them. She said she stayed on them about getting their trainings done. She said there was usually one aide assigned to each hall except for hall 2 that sometimes had 2 aides. She said on yesterday 6/27/2024 when NA L worked, she was only supposed to assist with personal care and not provide care by herself and was not aware that she had been providing care on her own. She said she was not certain how many months the non-certified staff had to be certified. During an interview on 6/28/2024 at 12:13 PM, Regional Nurse Consultant HH said she was a NATCEP Program Director, and the facility was not part of the program. She said the staff needed to take a course on their own because the waiver had ended April 30, 2024. She said the non-certified aides were not to provide any hands-on care and was not aware that they were. She said staff should be certified within 4 months of hire. She said there was a risk for injury and negative outcomes if staff were allowed to work and provide personal care and not have proper training. She said her expectations were that they become certified and if they have had their hours of training, they had to get certified within the allotted time frame and work alongside a certified nurse aide, only if they have had their proper training. Attempted an interview on 7/1/2024 at 1:00 PM, HR was out of the facility on vacation and not available by phone. (continued on next page)		

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/1/2024 at 1:31 PM, the Administrator said the facility had a total of 10 non-certified aides. She said she was aware that the non-certified aides were assigned halls by themselves but was not aware they were providing care by themselves. She said the DON and both ADON's were responsible for ensuring trained staff were working the halls and providing personal care. She said the DON and ADON's were responsible for ensuring they received the appropriate training to become certified and should be certified within the 4-month time frame and that they could not be providing any direct care to the residents alone. She said they can pass ice and make beds only. She said she expected all aides would be certified and that no hospitality aide could work unless working directly with a certified nurse aide. She said there was a risk for residents not receiving care they needed and deserved. Record review of a facility policy titled Nursing Services and Sufficient Staff dated 4/10/2022 indicated, .It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 6. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for the residents' needs . Record review of a Long-Term Regulatory Provider Letter 2023-05 revised 5/8/2023 indicated, .Nurse aide Hire date begins on or after 5/11/2023-certification date 4 months from date of hire . Record review of Nurse Aide job description, undated, reflected: nurse aides were to complete a nursing and competency program and become certified without a precise time stated.		