STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675976	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winfield Rehab & Nursing	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 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50818 Based on observation, interview and record review the facility failed to ensure that residents were free from physical and chemical restraints imposed for purposes of discipline or convenience and were not required to treat the resident's medical symptoms for 1 of 11 residents (Resident #8) reviewed for restraints. The facility failed to ensure Resident #8 was free from physical restraint when CNA A physically restrained him during incontinence care on 4/27/25. An Immediate Jeopardy (IJ) situation was determined to have existed between 4/27/2025 to 4/28/25. It was determined to be past non-compliance due to the facility having implemented actions that corrected the non-compliance prior to the beginning of the survey. This failure could place residents at risk for physical restraint. Findings include: Record review of Resident #8's admission record, dated 5/1/25, indicated Resident #8 was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #8 had a primary diagnosis which included Alzheimer's Disease (progressive brain disorder that slowly damages memory, thinking, and behavior) and secondary diagnoses which included Ataxia (lack of muscle coordination and control) and cognitive communication deficit (difficulty communicating). Record review of Resident #8's MDS, dated [DATE], revealed he had a BIMS of 3, which indicated severe cognitive impairment. He was dependent on staff for toileting hygiene, shower/bath, putting on/taking off footwear, and lower body dressing; he required maximum assistance with oral hygiene and personal hygiene. He was able to eat independently. He was always incontinent of bowel and bladder. Record review of Resident #8's comprehensive care plan, revision on 11/15/23 , indicated Resident #8 had impaired cognition and was at risk for further decline related to a diagnose of Alzheimer's Disease. Interventions were in place which indicated identifying yourself at each interaction, provide clear instructions using simple sentences, and stopping personal care to return later if he became agitated. (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 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a witness statement, dated 4/27/25 given by RN C, indicated she saw CNA B leave Resident #8's room crying. RN C said CNA B told her Resident #8 was swinging his arms and CNA A grabbed Resident #8's hands and pushed them into resident's chest. The same witness statement indicated RN C removed CNA A from Resident #8's room and notified the ADM. During an observation on 4/29/25 at 12:00 p.m. revealed Resident #8 was sitting in a geri chair (specialized recliner) in the day room watching television; he appeared to be clean and well groomed, with no offensive odors. There were no visible skin tears, marks, or bruising on his skin. Resident #8 became agitated in response to attempted interview as indicated by fidgeting in his chair and raising his voice shouting no. Observation of a video recording (8 seconds long with no visible time stamp or date) from Resident #8's in-room camera showed CNA A physically restraining Resident #8 by pushing Resident #8's hands into his chest and holding him down on the bed. Resident #8 can be heard crying out in the video clearly stating Ow. During an interview on 4/30/25 at 11:20 a.m., the ADM said CNA A was agency staff and completed all his required training through that agency. The ADM said CNA A had not worked at the facility previously and Resident #8 was his first interaction with a resident at the facility. The ADM said CNA B went into Resident #8's room to assist CNA A with incontinent care. The ADM said CNA B left the room and reported to RN C that CNA A was being rough with Resident #8. The ADM said RN C notified him of alleged abuse and he suspended CNA A immediately pending investigation. The ADM said he requested video from the camera in Resident #8's room but Resident's RP (responsible party) was unable to send the video. The ADM said RP sent a video clip that would not open. The ADM said CNA A was sent home immediately pending investigation and would not be allowed back at the facility. During an interview on 4/30/25 at 6:15 p.m., CNA B said she went into Resident #8's room with CNA A to assist with incontinent care. She said Resident #8 was sleeping, and CNA A yanked his blankets off him. She said Resident #8 woke up startled and grabbed her hand and started squeezing it. She said CNA A grabbed Resident #8's hands, pushed them down into his chest, and held him down on the bed. CNA B said she told CNA A they wouldn't be able to change the resident right now because he was upset, but CNA A insisted they could and told her to go get the Hoyer lift so they could transfer Resident #8 to his chair. CNA B said she left the room and reported to the charge nurse, RN C, that CNA A was being rough with Resident #8. During a telephone interview on 5/1/25 at 8:19 a.m., CNA A said he and CNA B went into Resident #8's room to assist with incontinent care. CNA A said he woke Resident #8 up, introduced himself, and explained the care he was going to provide. CNA A said when he attempted to roll Resident #8 onto his side Resident #8 became combative and grabbed CNA B's hand and squeezed it. CNA A said CNA B told him they wouldn't be able to change Resident #8 right now because of his behaviors. CNA A said he continued to try and change Resident #8's brief and Resident #8 began swinging his fists around. CNA A said he grabbed Resident #8's hands and held them down to the resident's chest to avoid injuries. CNA A said he knew he was not supposed to physically restrain a resident; he said he should have left the room and come back later to provide care . CNA A said RN C told him to leave the resident room and informed he was being suspended pending investigation. He did not know why he did not leave the room to return later. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/1/25 at 9:10 a.m. Resident #8's RP said she was notified on 4/27/25 of the alleged abuse and watched the video recording from the camera in Resident #8's room. The RP said CNA A and CNA B went into Resident #8's room and CNA A yanked the blankets off him. The RP said Resident #8 was scared and became combative with staff, grabbing CNA B's hand. The RP said CNA A grabbed Resident #8's hands and pushed them down into his chest, holding him down on the bed. She said CNA B told CNA A she was going to get the nurse and left the room. The RP said she did not know how to send the entire video of the incident from the in-room camera, but was able to send an 8 second clip to the ADM. Record review of CNA A personnel file indicated all required background checks and abuse, neglect, and exploitation training had been completed by CNA A's staffing agency. Record review of the facility policy titled Restraint Free Environment, dated 10/24/22, indicated It is the policy of this facility that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which resident has medical symptoms that warrant use of restraints It was determined these failures placed residents in an IJ situation on 4/27/25 to 4/28/25. The facility corrected the noncompliance on 4/28/2025 by the following: CNA A was immediately removed from resident care and suspended then terminated. Appropriate notifications to abuse coordinator, RP and providers were made Began ongoing in-service on 4/27/25 for all staff which covered abuse/neglect and required reporting to the facility abuse coordinator. Began ongoing in-service for all staff dated 4/27/25 which covered using no force or minimal force with residents and reporting any pain during personal care to charge nurse . The in-service was provided to all-staff members. Completed QAA Resident Questionnaires, dated 4/28/25, indicated 10 of 10 residents interviewed had not experienced any physical or verbal mistreatment, were treated with dignity and respect, and felt safe in the facility. Staff interviews conducted with staff of varying disciplines on two separate shifts including LVN (3), RN (1), CNA (7), CMA (1), LCSW (1) revealed all staff interviewed were had received abuse and neglect training upon hire, annually, and had additional in-services covering abuse, neglect, mandatory reporting, and using minimal force with residents.

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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 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** 50818 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 11 residents (Resident #1) reviewed for accidents. The facility failed to keep Resident #1 in a safe environment to prevent an elopement on 4/24/2025 when she followed a visitor out of the facility. An Immediate Jeopardy (IJ) situation was determined to have begun on 4/24/2025 and ended on 4/28/25. It was determined to be past non-compliance due to the facility having implemented actions that corrected the non-compliance prior to the beginning of the survey. This failure could place residents at risk for serious injury and accidents. Findings include: Record review of Resident #1's admission record, dated 5/1/2025, indicated a [AGE] year-old female who was readmitted to the facility on [DATE]. Resident #1 had diagnoses which included unspecified dementia (decline in cognitive function), anxiety disorder , and senile degeneration of brain (mental deterioration associated with aging). Record review of Resident #1's MDS, dated [DATE], indicated she had a BIMS of 6, which indicated severe cognitive impairment. She required moderate assistance with eating; she required maximum assistance with oral hygiene, upper body dressing, and personal hygiene; she was dependent on staff assistance for showering/bathing, putting on/taking off clothes, putting on/taking off footwear, and toileting hygiene. She was frequently incontinent of bowel and bladder. She had no history of wandering behavior. Record review of Resident #1's comprehensive care plan, dated 4/5/25, indicated she was at risk for falls and further cognitive decline. Interventions were in place which included identify yourself at each interaction, reduce distractions, and ensuring resident was wearing appropriate footwear when ambulating. Record review of Resident #1's elopement assessments, dated 3/15/25 and 3/22/25, indicated she had an elopement risk score of 0 which indicated lowest risk. Record review of incident report #1122 for an elopement dated 4/24/25 indicated the facility was notified of Resident #1's elopement at approximately 8:35 p.m. The same incident report indicated ADM was notified of the elopement at 8:42 p.m. and staff were sent to escort Resident #1 back to the facility. Post-incident assessment completed on 4/24/25 at 9:00 p.m. indicated resident was alert and oriented to person, place, time, and situation, and had no injuries noted. (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 a progress note, dated 4/24/25 at 6:30 p.m. by LVN G, indicated resident was noted behind the nurse's station trying to use the phone to go home; education and redirection was ineffective. Record review of progress note, dated 4/24/25 at 7:26 p.m. by LVN G, indicated resident asked her what would happen if she opened the door. LVN G noted resident standing up by the door and walking back and forth; education and redirection was ineffective. During an observation and interview on 4/29/25 at 11:00 a.m., Resident #1 was in her room sitting on the bed, she appeared clean and well-groomed with no offensive odors; she had no visible skin tears, marks, or bruising. Resident #1 said she left the facility because she wanted to go home. Resident #1 said she asked a nurse to open the door for her to go home and the nurse refused, so when she saw people exiting the facility and she followed them out. During an interview on 4/30/25 at 11:00 a.m., Regional Consultant Nurse (RNC) said the facility first learned of the elopement when staff at the nursing facility next door called to ask if Resident #1 was a resident at their facility. She said Resident #1 used to work as a CNA and had gone to the nursing facility next door thinking she was going to work. The RNC said Resident #1 had no previous history of wandering or exit-seeking behaviors and her prior elopement scores were all 0. The RNC said the first time Resident #1 exhibited wandering or exit-seeking behaviors was on 4/24/25, the day of the elopement. The RNC said LVN G had identified these behaviors and charted them in Resident #1's medical record but did not notify any other staff or do anything to intervene. The RNC said two staff members assisted Resident #1 back to the facility and she was immediately assessed for injuries with non noted and placed on 1-to-1 observation . The RNC said Resident #1 would remain on 1-to-1 observation until psychiatric services evaluated the resident. She said all resident's had new elopement assessments completed and placed into the elopement binder at the nurses' station. She said LVN G was suspended pending the investigation. During an interview on 4/30/25 at 11:20 a.m., the ADM said the facility was unable to determine how Resident #1 exited the facility. The ADM said Resident #1 stated she saw visitors exiting the facility and asked them to hold the door for her and followed them out. The ADM said when the facility was notified of the elopement maintenance tested all the door magnetic locks and alarms and they were functioning correctly. The ADM said Resident #1 was immediately placed on 1-to-1 supervision and the facility in-serviced all staff on abuse, neglect, exploitation and missing resident policies and held elopement drills with staff . During an interview on 4/30/25 at 2:00 p.m., the Maintenance Director said following the elopement on 4/25/24 he verified all door locks and alarms were functioning and hung signs on the exit doors to alert visitors that residents may try to follow them out. He said he was responsible for completing regular weekly checks of door locks and alarms and recording the inspections in a logbook. He said he had not identified any concerns related to the door locks or alarms. During an observation on 4/30/25 from 2:15 p.m. - 2:45 p.m. revealed the Maintenance Director checked all door magnetic locks and alarms; the locks functioned properly, and alarms were audible . Each exit door had a sign posted, prominently displayed at eye-level, indicating a resident could attempt to follow visitors out. Interview attempted for LVN G - phone calls were not returned. (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 elopement incident report, dated 4/24/25, indicated at 8:35 PM a CNA at the next-door nursing facility called and reported Resident #1 was at their facility asking to use a phone to call her family to go home. The incident report indicated Resident #1 was alert and oriented to person, situation, place, and time and had no noted injury . Record review of the facility's policy titled Missing Resident Policy, last revised 8/15/23, indicated .This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk It was determined these failures placed residents in an IJ situation on 4/24/25 to 4/28/25. The facility corrected the noncompliance on 4/28/2024 by the following: Resident #1 placed on 1-to-1 supervision pending psychiatric evaluation to determine safe placement. Resident head counts conducted on 4/24/25 following elopement accounted for all residents. New elopement assessments completed for all residents and placed in elopement binder located at nurse's station. All exit doors locks and alarms were checked by facility maintenance staff and verified to be functioning. Each exit door had a sign posted, prominently displayed at eye-level, indicating a resident could attempt to follow visitors out. An associate disciplinary memo dated 4/25/25 indicated LVN G was suspended pending investigation. QAA Staff questionnaire dated 4/25/25 concerning resident's following staff out of building. Ad Hoc QAPI meeting held to develop a performance improvement plan and ensure safety of resident's going forward. Performance Improvement Plan, dated 4/24/25, titled Exit Seeking/Missing Resident indicated the following action items: 1.) The facility maintenance director and/or designee completed environmental assessments to include checking the function of all the facility exit doors to ensure proper function. 2.) Complete head to toe physical assessment performed by facility staff nurse and telehealth physician assistance, no injuries noted. 3.) Educate facility direct care staff on Missing Resident Policy. Document education using in-service sign in sheet so that compliance can be validated. 4.) Complete a missing resident drill with facility direct care staff. Document drill using drill sign in sheet so that compliance can be validated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5.) All facility residents were reassessed using the Elopement/Wandering Risk Assessments. No other like residents were identified. 6.) The DON /Designee will conduct weekly random missing resident drills two (2) times a week for six (6) weeks to ensure facility staff know the proper procedure for locating missing residents. Results of weekly observations will be reviewed in the facility morning meeting by the Administrator and/or designee. 7.) Review findings monthly at QAPI meeting for three months to ensure compliance. 8.) Conduct an AdHOC QAPI meeting regarding the facility resident exiting the facility and the facility's plan to follow up to sustain compliance. Physician progress notes, dated 4/25/25, indicated Resident #1 was seen by telehealth provider indicated exit-seeking behavior was an acute new problem and Resident #1's condition was stable. Review of a comprehensive care plan dated 4/25/25 showed care plan was updated to reflect wandering/exit seeking behavior with appropriate interventions in place to redirect resident from restricted areas and use verbal redirection to dissuade exit-seeking behavior. Completed in-service for all staff dated 4/24/25, topic discussed Do Not let any residents out the door without the charge nurse's permission. Completed in-service for all staff dated 4/25/25, topic discussed Missing Resident for all staff. Emergency Response Drill for missing resident, dated 4/25/25, a drill took place between 5:00 p.m. and 5:13 p.m . Emergency Response Drill for missing resident, dated 4/28/25, a drill took place between 3:22 p.m. and 3:25 p.m . Emergency Response Drill for missing resident, dated 4/28/25, a drill took place between 7:07 p.m. and 7:12 p.m . Record review of Elopement Binder indicated all residents had new elopement assessments completed on 4/24/25 . Record review of QAPI minutes from Ad Hoc meeting held on 4/25/25 at 1:15 p.m. to discuss facility's notification regarding Resident #1's elopement and plan to sustain compliance. Record review of a logbook titled Doors Mag Lock for April and March of 2025 indicated all weekly checks were completed and no problems were identified. Observations on 4/30/25 between 2:00 p.m. and 2:45 p.m. of facility exits revealed all magnetic locks and door alarms were functioning. Signs were prominently displayed at each door at eye-level notifying people exiting the facility to not allow residents to follow them out the door. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews with staff of various disciplines on two (2) different shifts were interviewed. All staff members said they attended in-service training after the elopement and topics covered not allowing residents to exit the facility without permission from the charge nurse and missing resident response. All staff were all able to verbalize appropriate action to take in the event of a missing resident including identifying exit-seeking behavior, immediately responding to door alarms, looking for missing resident inside the building, outside the building, and notifications including to local police. Staff were able to verbalize to be wary of residents following staff or visitors out of the building and not to allow residents to exit the building without permission from the charge nurse. Staff interviews included LVN (3) RN (1) CNA (7) CMA (1) LCSW (1).