

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 11/21/2025
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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals for one (Resident #1) of six residents reviewed for pharmaceutical services. The facility failed to ensure an unknown staff did not leave Resident #1's medications inside the resident's room for the resident to take unsupervised which resulted in her dropping one Colace pill and one Amlodipine pill on an unknown date. This failure could place the residents at risk of not receiving medications as ordered by the physician for 1 of 6 residents (Resident #1) reviewed for pharmaceutical services. Findings included: Record review of the face sheet dated 10/25/2025 indicated that Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including congestive heart failure, which is when the heart cannot pump blood throughout the body efficiently, generalized edema, which is swelling caused by fluid build-up, myocardial infarction, which is a blockage in the heart, chronic obstructive pulmonary disease, which is when airflow gets trapped in your lungs making it feel difficult to breathe, constipation which is when you cannot have regular bowel movements, essential hypertension which is high blood pressure with no clear cause. Record review of the MDS dated [DATE] indicated that Resident #1 had a BIMS score of 15. Her score indicated that she had normal cognition, and no major memory or cognition issues. Record review of Resident #1's Medication Review, dated 10/16/25, revealed an order for amlodipine 10mg, give 1 tab by mouth one time a day in the morning and Colace 100mg by mouth every 12 hours. Record review of the MARs dated 10/16/2025 revealed that Resident #1 was prescribed amlodipine 10mg, one tablet in the morning by mouth and Colace 100mg one capsule every 12 hours by mouth as part of her daily medication regimen. Record review of the facility policy entitled Medication Storage and dated 1/20/2021 which indicated that It is the policy of this facility to ensure all medications housed on our premises will be stored, dated and labeled according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms). During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. During an observation on 10/15/25 at 4:33 p.m. Resident #1's previous bedroom (room [ROOM NUMBER]) revealed two pills on the ground; one orange and one white, which were identified by the DON as Colace, a stool softener, and amlodipine which is a blood pressure medication. During an interview on 10/15/2025 at 12:50 p.m. Resident #1 stated that she found little white pills on the floor in her previous room which was room [ROOM NUMBER] and that the med aides or nurses did not wait for her to take her medication and she thought she dropped some of her pills. Resident #1 stated that the staff got in a hurry and that she didn't have time to ask them what she was taking. During an interview on 10/15/25 at 4:40 p.m. LVN C stated that the pills could have gotten on the floor from the resident spitting them out when the staff was not looking, or the staff dropped the pills and did not pick them up. She stated that the pills should not have been on the floor and that there was a risk of another resident finding the medication. LVN C said taking it could cause adverse health effects and there was a risk of the resident whose medication it was missing a dose, as it could have also caused them adverse health effects. During an interview on 10/15/25 at 4:43 p.m. MA A stated that the pills could have gotten on the floor from the resident spitting them out when the staff is not looking. She stated that the staff could have dropped the pills and did not pick them up. She stated that the pills should not have been on the floor and that there was a risk of another resident finding the medication. MA A stated taking the medication if it was not prescribed to you could have caused adverse health effects and there was a risk associated with missing a dose of the medication if it was prescribed to you, as it might have caused adverse health effects. During an interview on 10/15/25 at 4:50 p.m. the DON stated that the pills could have gotten on the floor from the resident spitting them out when the staff is not looking, or the staff could have dropped the pills and not picked them up. She stated that the pills should not be on the floor and that there is a risk of another resident finding the medication. The DON said taking the medication if it was not prescribed to you for your specific medical condition it could have caused adverse health effects. She stated that there is a risk of the resident whose medication it was missing a dose, as it can also cause them adverse health effects. During an interview on 10/16/25 at 12:08 p.m. MA B stated that the pills could have gotten on the floor from the resident spitting</p>		