

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

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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 12/10/2025
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)		
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to use the services of a registered nurse for at least eight consecutive hours a day, 7 days a week for 2 of 3 months reviewed. (July 2025 and August 2025)The facility did not have RN coverage for 2 days in July 2025 (7/26/2025 and 7/27/2025).The facility did not have RN coverage for 2 days in August 2025 (8/02/2025 and 8/03/2025).This failure could place residents at risk by leaving staff without supervisory coverage for RN specific nursing activities and for coordination of events such as emergency care and disasters. Findings included:Record review PBJ Staffing Data Report fiscal year Quarter 4 2025 (July 1 - September 30) indicated No RN Hours 07/01 (TU); 07/02 (WE); 07/03 (TH); 07/04 (FR); 07/05 (SA); 07/06 (SU); 07/07 (MO); 07/08 (TU); 07/09 (WE); 07/10 (TH); 07/11 (FR); 07/12 (SA); 07/13 (SU); 07/14 (MO); 07/15 (TU); 07/16 (WE); 07/17 (TH);07/18 (FR); 07/19 (SA); 07/20 (SU); 07/21 (MO); 07/22 (TU); 07/23 (WE); 07/24 (TH); 07/25 (FR); 07/26 (SA); 07/27 (SU); 07/30 (WE); 07/31 (TH) 08/02 (SA); 08/03 (SU); 08/04 (MO); 08/05 (TU); 08/07 (TH); 08/08 (FR); 08/11 (MO); 08/13 (WE); 08/14 (TH); 08/15 (FR); 08/16 (SA); 08/17 (SU); 08/23 (SA); 08/24 (SU); 08/30 (SA); 08/31 (SU) 09/01 (MO); 09/02 (TU); 09/13 (SA); 09/14 (SU); 09/20 (SA); 09/21 (SU).Record review of facility time punch report dated from 7/01/2025 to 9/30/2025 indicated the facility had RN coverage in the facility on all dates except 7/26/2025, 7/27/2025, 8/02/2025, and 8/03/2025.During an interview on 12/10/2025 at 2:18 pm the Regional Nurse Consultant said she was the RN coverage from July 2025 to September 2025 due to no DON in the facility at that time and she was responsible for staffing. She said she was unsure why there was no RN coverage on 7/26/25, 7/27/25, 8/02/25 and 8/03/25. The current DON assumed the staffing role in September 2025. She said if there was no RN coverage 7 days a week 8 hours a day then oversight of situations could be affected. During an interview on 12/10/2025 at 2:25 pm the Administrator said that the DON was responsible for staffing and during that time the DON was covered by the regional nurse and was not aware that there were days an RN was not in the facility for the required 8 hours. She said she expected the RN coverage to occur daily as regulated to prevent any care issues. 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. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment. 8.Except when waived, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week .		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675976
		If continuation sheet Page 1 of 15

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS reviewed for administration (Fiscal year 2025 for the fourth quarter July 2025 to September 2025).The facility failed to submit accurate RN hours for:07/01 (TU); 07/02 (WE); 07/03 (TH); 07/04 (FR); 07/05 (SA); 07/06 (SU); 07/07 (MO); 07/08 (TU); 07/09 (WE); 07/10 (TH); 07/11 (FR); 07/12 (SA); 07/13 (SU); 07/14 (MO); 07/15 (TU); 07/16 (WE); 07/17 (TH);07/18 (FR); 07/19 (SA); 07/20 (SU); 07/21 (MO); 07/22 (TU); 07/23 (WE); 07/24 (TH); 07/25 (FR); 07/26 (SA); 07/27 (SU); 07/30 (WE); 07/31 (TH) 08/02 (SA); 08/03 (SU); 08/04 (MO); 08/05 (TU); 08/07 (TH); 08/08 (FR); 08/11 (MO); 08/13 (WE); 08/14 (TH); 08/15 (FR); 08/16 (SA); 08/17 (SU); 08/23 (SA); 08/24 (SU); 08/30 (SA); 08/31 (SU) 09/01 (MO); 09/02 (TU); 09/13 (SA); 09/14 (SU); 09/20 (SA); 09/21 (SU).These failures could place residents at risk for personal needs not being identified and met. Findings:Record review PBJ Staffing Data Report fiscal year Quarter 4 2025 (July 1 - September 30) indicated No RN Hours 07/01 (TU); 07/02 (WE); 07/03 (TH); 07/04 (FR); 07/05 (SA); 07/06 (SU); 07/07 (MO); 07/08 (TU); 07/09 (WE); 07/10 (TH); 07/11 (FR); 07/12 (SA); 07/13 (SU); 07/14 (MO); 07/15 (TU); 07/16 (WE); 07/17 (TH);07/18 (FR); 07/19 (SA); 07/20 (SU); 07/21 (MO); 07/22 (TU); 07/23 (WE); 07/24 (TH); 07/25 (FR); 07/26 (SA); 07/27 (SU); 07/30 (WE); 07/31 (TH) 08/02 (SA); 08/03 (SU); 08/04 (MO); 08/05 (TU); 08/07 (TH); 08/08 (FR); 08/11 (MO); 08/13 (WE); 08/14 (TH); 08/15 (FR); 08/16 (SA); 08/17 (SU); 08/23 (SA); 08/24 (SU); 08/30 (SA); 08/31 (SU) 09/01 (MO); 09/02 (TU); 09/13 (SA); 09/14 (SU); 09/20 (SA); 09/21 (SU).Record review of facility time punch report dated from 7/01/2025 to 9/30/2025 indicated facility had RN coverage in the facility on all dates except 7/26/2025, 7/27/2025, 8/02/2025, and 8/03/2025.During an interview on 12/10/2025 at 2:17 PM the Administrator said that she completed the spreadsheet for the RN hours worked and submitted them to an offsite person at the corporate office to input the data into PBJ. She said she was not aware that he had inaccurately reported the hours. She said inaccurate reporting could affect the facility's quality measures.Attempted phone call on 12/10/2025 at 2:40 pm to corporate office regarding PBJ reporting with no answer and voicemail left. 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. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment. 7.The facility is responsible for submitting timely and accurate staffing data through the CMS Payroll? Based Journal (PBJ) system .		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared, and distributed under sanitary conditions in 1 of 1 kitchen reviewed for kitchen sanitation in that: The facility failed to ensure the dish machine reached recommended minimal 50-100 parts-per-million, (PPM), of hypochlorite (chlorine) during the final rinse cycle of the facility dish machine on 12/8/2025. This failure could place the residents at risk of foodborne illnesses. Findings included: During an observation and interview on 12/8/2025 at 9:41 AM the dish machine was checked by the DM. She tested the hypochlorite (chlorine) after the final rinse cycle, and it registered at 10 ppm. She said it should be at least 50-100 ppm of hypochlorite. She said she would contact the technician contracted for the dish machine for service. She said she would shut the dish machine down and use disposable plates and utensils until it was repaired. She said if the dish machine did not have the proper amount of sanitization chemicals the dishes might not be clean enough and could make someone sick. During a follow up observation on 12/8/2025 at 4:34 PM in the kitchen, the dish machine was tested, and the hypochlorite was 50 ppm meeting regulation and policy. During an interview on 12/10/2025 at 2:30 PM, the Administrator said the technician for the dish machine repaired it and increased the sanitizer for the dish machine. She said the dish machine should be checked daily by the kitchen staff. She said if the dish machine did not have the correct amount of sanitizer chemical, then the dishes would not get cleaned or sanitized properly and there could be a risk for spreading infections. Record review of a service report from the contract company for the kitchen on 12/8/2025 indicated a tech went to the facility to service the dish machine not sanitizing properly. A micro pump motor was replaced, and sanitizer solution was increased. Record review of a facility policy titled Ware Washing revised 5/2018 indicated, .The purpose of ware washing is to clean and sanitize utensils and equipment used during the preparation and service of food from the dietary department. Proper ware washing is an essential component in the prevention of food borne illnesses. 4. Improper temperatures and/or sanitizer strength will be reported to the person in charge immediately and manual ware washing and/or paper products will be implemented until the problem is corrected. 2. Low temperature dish machines: a: 120 degrees= minimum water temperature for both wash and rinse cycles, b. chemical: chlorine sanitizer=50-100 ppm (parts per million) .		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review the facility failed to maintain all essential equipment in safe operating condition, for 1 of 1 stove reviewed for food service in that: The facility did not ensure the gas stove was in working order. Two of six gas stove burners (left front and left back) did not light properly when the knob was turned. This failure could place residents who eat out of the kitchen at risk of injury and undercooked food. Findings include: During an observation and interview on 12/8/2025 at 9:36 AM, the gas stove had six burners total, two burners on the left front and left back did not light completely when the knob was turned and only half of the burner was lit. The DM said the stove had been that way for 2 years since she started at the facility and the kitchen staff does not use those two burners. She could not answer what could happen if they did not light properly. She said she would let the Administrator know about the stove. During an interview on 12/10/2025 at 2:30 PM, the Administrator said the burners on the stove were reported to the Maintenance Supervisor and someone was going to come to the facility that day. She said if the burners did not light properly, it could take longer to cook or have a gas leak. She said she was not aware of the burners on the stove prior to Monday 12/8/2025. During an interview on 12/10/2025 at 2:25 PM, the Maintenance Supervisor said he was not made aware of the burners on the stove not working properly until yesterday 12/9/2025. He said someone was coming to the facility that day to look at it. He said sometimes the kitchen staff would report issues to him but not all the time. He said if the burners did not light properly, he did not know of a risk and what could happen. On 12/9/2025 Surveyor requested a policy for the stove, and none was provided by the time of Surveyor exit on 12/10/2025.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to incorporate recommendations from a PASARR (Preadmission Screening and Resident Review) evaluation report into a resident assessment, care planning, and transition of care for 2 of 9 (Resident # 7 and Resident #9) residents reviewed for PASARR services. The facility failed to submit a complete and accurate request for NF specialized services in the LTC online portal within 20 business days after the date of the Interdisciplinary Team (IDT) meeting on [DATE]. This failure could place residents at risk of not receiving specialized PASARR services which would enhance their highest level of functioning and could contribute to residents' decline in physical, mental, and psychosocial well-being. Findings included: 1. Record review of an admission Record for Resident #7 dated [DATE] indicated she admitted to the facility [DATE] and expired on [DATE]. She was [AGE] years old with diagnoses of adult failure to thrive (a decline in health with weight loss), polyneuropathy (a condition when the nerves outside the brain or spinal cord are damaged), cerebral infarction (stroke) and GERD (acid reflux). Record review of a Significant Change MDS Assessment for Resident #7 dated [DATE] indicated she did not have any impairment in thinking with a BIMS score of 15. Record review of a Care plan for Resident #7 dated [DATE] and revised on [DATE] indicated she was PASARR positive with ID. Interventions included that the facility would maintain the PL1, PE, and IDT minutes in the resident's medical record. Record review of a PASARR Comprehensive Service Plan (PCSP) for Resident #7 dated [DATE] indicated she had an initial meeting and Specialized OT was new. All services were agreed upon at the meeting for initial services. Record review of a PASARR Evaluation for Resident #7 dated [DATE] indicated she had ID. Record review of a PASARR Level 1 Screening for Resident #7 following a readmission into the facility dated [DATE] indicated dementia was her primary diagnosis but she also had an intellectual disability. Record review of SIMPLE (an online portal for long term care facilities) for Resident #7 revealed there was not a NFSS form that was submitted for the resident following the PCSP meeting held on [DATE] for OT services. 2. Record review of an admission Record dated [DATE] for Resident #9 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of end stage renal disease, intellectual disabilities (a disability that involves limitations on thinking, learning and tasks of daily living) and down syndrome. Record review of a Quarterly MDS assessment dated [DATE] for Resident #9 indicated she had severe impairment in thinking with a BIMS score of 6. She used a wheelchair for mobility. During the 7 day look back period she received OT and PT services at least 15 minutes a day on one or more days. Record review of a NFSS therapy signature page dated [DATE] for Resident #9 was signed by the Therapist and the Administrator at that time. Record review of a PCSP for Resident #9 dated [DATE] indicated it was an annual meeting that was held. Specialized OT was a new service requested, and services were agreed upon. Record review of a PE for Resident #9 dated [DATE] indicated she had ID, DD. Record review of a PASARR Level 1 Screening for Resident #9 dated [DATE] indicated she was positive for ID and DD. Record review of a care plan revised [DATE] for Resident #9 indicated she had been deemed PASARR positive on the PASARR evaluation which may place her at risk for not having the ordered specialized services provided. Interventions included specialized services determined to be necessary by the IDT will be initiated and request submitted to DADS within 20 days after date of IDT. During an observation and interview on [DATE] at 3:46 PM, Resident #9 was in her room sitting on the side of her bed looking at her phone. She was alert to person and place. She said she had received therapy but was not receiving therapy at that time. During a phone interview on [DATE] at 3:57 PM, the RP for Resident #9 said she was the contact person for the resident but did not make any decisions for her. She said she had known the resident for many years, and the facility contacted her when there were changes but had not been involved in (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any care plan meetings and was not aware of what services were agreed upon during the care plan meetings. During a phone interview on [DATE] at 1:43 PM, CNA F said she had been employed at the facility for 3 years but was recently demoted from a case manager position where she helped with admissions and PASARR. She said she was trained by the MDS Coordinator and the SW on PASARR. She said she attended the IDT meetings for PASARR and helped with entering in the IDT meeting in the portal after the meetings. She said she had been asleep and could not recall a meeting in [DATE] and was not aware of any email that was sent by the PASARR following a meeting in [DATE]. During an interview on [DATE] 2:02 PM, the Habilitation Coordinator was in the facility. She said she visited the facility monthly and checked on each resident that was PASARR positive. She said the facility had meetings for the residents after their initial evaluation and then annually and some had quarterly meetings between times. She said she has been the Habilitation Coordinator for the facility since late [DATE]. She said she was not the coordinator for the facility in [DATE]. She said Resident #7 had a PE on [DATE] and an initial meeting on [DATE]. She said if a resident had an initial meeting, then the nursing facility staff should have entered in the meeting information into Simple after the IDT. She said during the initial meeting that PT was pending, and OT was a new service that was requested. She said Resident #9 had an annual meeting on [DATE] and OT was a new service that was requested. She said after the meeting the facility should have entered an NFSS for both residents with new therapy services requested. She said if services were not provided the residents would not get the therapy they were requesting. During an interview on [DATE] 2:22 PM, the SW said the NFSS forms should be entered by therapy into the online portal. She said she worked at the facility in [DATE] and left for a short time and was rehired in [DATE]. She said she was not aware of the PASARR unit reaching out to the facility requesting information. She said she was not sure how long the facility had to submit the NFSS form for therapy into the portal. She said she was responsible for all things PASARR now and worked in the facility 2 days a week. During an interview on [DATE] 3:05 PM, the DOR said she started at the facility [DATE]. She said the facility had been without a DOR for about 3 months prior to her starting at the facility. She said she had just attended her first PASARR meeting that day and Resident #9 was discussed. She said the NFSS form would be completed by therapy and was not sure of the timeframe that they had to be entered into the portal. She said services could be denied or residents might not get the requested services if the forms were not submitted in a timely manner. She said Resident #9 had an evaluation for PASARR and received therapy from [DATE] to [DATE] for OT services. She had a recertification on [DATE] for OT and could not find a NFSS form in Simple for [DATE]. She said Resident #7 admitted to the facility on [DATE] and they billed her Medicare part B for therapy services. She said on [DATE] they started an initiation through PASARR for PT, OT, and ST. She said Resident #9 had an NFSS form that was submitted on [DATE] into SIMPLE that was returned due to the signatures and was not resubmitted. She said Resident #7 did not have an NFSS form that she could see in SIMPLE for her. During a follow up interview on [DATE] at 3:45 PM, the Administrator said she started at the facility [DATE]. She said she missed the email that was sent by the PASARR unit in [DATE] and it was an oversight. She said she was not aware the facility should have been checking the online portal for updates to approval for PASARR services. She said at that time CNA F was standing in doing PASARR and was told she had been trained, but when she found she was not a social worker she decided the facility needed a social worker in that position. She said the MDS Coordinator would be responsible for PASARR now and the SW would help with it as well. She said she would check SIMPLE and TMHP for updated information and would be providing oversight. She said residents could miss requested services if the information was not submitted in a timely manner. She said she was not aware that Resident #7 and Resident #9 had a service that was requested but did not receive it. Record review of a facility policy titled Preadmission Screening Resident Review revised 7/2023 indicated, .The purpose of this guideline is to direct the user through the PASRR procedures. Facility initiated Specialized Services by submitting request to DADS within 20 days of PCSP meeting .		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain grooming, and personal and oral hygiene were provided for 2 of 12 residents (Resident #16 and #29) reviewed for ADL care. 1. The facility failed to ensure Resident #16 did not have a thick, black substance under his nails on 12/8/2025 and 12/9/2025. 2. The facility failed to ensure Resident #29 had clean clothing on 12/08/2025. These failures could place residents at risk of not receiving care/services, decreased quality of life, and loss of dignity. Findings included: 1. Record review of an admission Record for Resident #16 dated 12/9/2025 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of dementia (loss of mental ability that can interfere with normal activities of daily living), schizophrenia (mental condition that affects how people think, feel, and behave), blindness in right eye and hypertension. Record review of a task documentation for Resident #16 dated 12/10/2025 indicated he received a bath on 12/7/2025. Record review of an admission MDS Assessment for Resident #16 dated 10/1/2025 indicated he had severe impairment in thinking with a BIMS score of 3. He required partial/moderate assistance where the helper does less than half the effort with personal hygiene. He required substantial/maximal assistance with shower/bathing. Record review of a care plan for Resident #16 revised on 10/31/2025 indicated he had an ADL self-care performance deficit and was at risk of not having his needs met in a timely manner. Interventions included to provide showers, shave, oral care, hair care, and nail care per schedule and when needed. Record review of an undated shower schedule for Resident #16 indicated his shower days were on Tuesday, Thursday, and Saturday. During an observation and interview on 12/8/2025 at 10:37 AM, Resident #16 was in bed awake and dressed. He said he had not been at the facility long and things were going well. His fingernails had a thick, black substance underneath them and he said he was not sure what days his showers were scheduled for. He said his last shower was one day last week but did not remember the day. During an observation on 12/8/2025 at 4:12 PM, Resident #16 was in bed resting with his eyes closed. His fingernails still had a thick, black substance underneath them. During an observation on 12/9/2025 at 8:07 AM, Resident #16 was in his room in bed. His fingernails still had a thick, black substance underneath them. During an interview on 12/9/2025 at 2:51 PM, CNA E said she gave Resident #16 a shower earlier that day. She said his fingernails had been trimmed and cleaned before she gave him a shower. She said if residents were diabetic, the nurse aides could not trim the resident's nails, but they could clean them. She said nails should be cleaned as needed and on their shower days. 2. Record review of Resident #29's facility face sheet dated 12/09/2025 indicated Resident #29 was a [AGE] year-old male that was originally admitted to the facility on [DATE] and readmitted on [DATE] for diagnosis of Alzheimer's. Record review of Resident #29's comprehensive care plan dated 09/11/2023 revealed Resident #29 had an ADL self-care performance deficit and was at risk of not having their needs met in a timely manner and for him to maintain a sense of dignity by being clean, dry, odor free, and well-groomed. Record review of Resident #29's quarterly MDS assessment dated [DATE] revealed Resident #29 had a BIMS of 99 indicating inability to complete the interview. A SAMS was completed and indicated Resident #29 had severe cognitive impairment for daily decision making. During an observation on 12/08/2025 at 10:54 AM Resident #29 was sitting in a geriatric chair in the dining room and his shirt and pants were soiled with food. During an observation on 12/08/2025 at 11:56 AM Resident #29 was in the dining room for lunch with same shirt and pants soiled with food. During an observation on 12/08/2025 at 2:11 pm Resident #29 was asleep in bed and continued to wear the same soiled shirt and pants. During an interview on 12/08/2025 at 2:33 pm CNA A said she was assigned to Resident #29. She said that residents that could not change their clothes themselves, the CNA did it for them. She said that when a resident's clothes were soiled then the CNA was to change them. She said if a resident's (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clothes were left soiled then it looked bad. During an observation on 12/08/2025 at 4:32 pm Resident #29 was in the dining room for dinner and continued to have on the same soiled shirt and pants. During an interview on 12/08/2025 at 4:36 pm CNA A said she should have changed Resident #29's clothes when they got soiled and especially before she got him back up for dinner. She said leaving residents in soiled clothes could affect them but could not say how. During an interview on 12/09/2025 at 8:30 am LVN B said that the CNA's care was overseen by the charge nurses and residents that are dependent should have their soiled clothes changed and then as needed. She said residents that were left soiled could affect their well-being and dignity. During an interview on 12/09/2025 at 8:45 am the DON said that the CNAs were responsible for providing ADL care to the residents, but all staff should be aware of any issues and ensure residents received care. She said she expected no resident to be left in soiled clothes as it was a dignity issue. During an interview on 12/9/2025 at 2:56 PM, the DON said she had been employed at the facility since August 2025. She said she conducted a nail inspection in the facility last night (12/8/2025) and she trimmed and cleaned Resident #16's nails that morning. She said the staff clean the resident's nails whenever they take a shower and that it was at least 3 days a week. She said it would make her feel nasty if she was dependent on staff to clean her nails. During an interview on 12/10/2025 at 2:20 PM, the Administrator said nail care and ADL care were the responsibility of the nurses and nurse aides. She said nail care should be done as needed and on shower days. She said she would not like it if she was dependent on staff to clean her nails. During an interview on 12/10/2025 at 2:25 pm the administrator said the DON was responsible for resident care but the charge nurses were to ensure the CNAs were providing care as the residents needed. She said she expected each resident to receive ADL care as they need it and residents that were left in dirty clothes could affect their dignity. Record review of a facility policy titled Clinical Practice Guideline Activities of Daily Living dated 1/23/2016 indicated, residents will receive essential services for activities of daily living to maintain good nutrition, grooming, and personal and oral hygiene. Record review of a facility policy titled Nail Care dated 4/25/14 indicated, .To provide for personal hygiene needs and prevent infection		

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **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 assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 3 medication carts (nurse cart for 300 hallway) reviewed for pharmacy services. The facility failed to dispose of expired insulin pens from the nurse medication cart for the 300 hall. These failures could place residents who receive medications at risk of not receiving the intended therapeutic benefit of the medications, decreased quality of life, and hospitalization. Findings included: Record review of the Physician Summary of orders dated 12/09/2025 indicated Resident #48 was a [AGE] year-old male admitted on [DATE]. His diagnosis included type 2 diabetes. An order dated 05/03/2025 indicated Resident #48 was to have Insulin Aspart Flex pen 100 unit/millimeter (Insulin) solution Inject as per sliding scale (amount of insulin given per level of blood sugar at time of testing): if 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 and greater notify physician, before meals subcutaneously for Type 2 Diabetes. Record review of the Physician Summary of orders dated 12/09/2025 indicated Resident #48 had an order dated 11/25/2025 for Lantus Solostar Subcutaneous Solution Pen-injector 100 unit/millimeter (Insulin Glargine) Inject 25 unit subcutaneously in the morning related to type 2 Diabetes. During an observation of the nurse medication cart for the 300 hall on 12/08/2025 at 10:45 AM with LVN C revealed the following: Insulin Aspart Flex pen (Insulin) solution 100 unit per milliliter flex pen with no open date with issue date of 08/08/2025. Pharmacy directions indicated to discard medication 28 days after the open date. During an interview on 12/08/2025 at 09:00 AM, the DON said she did not know the medication cart had expired insulins. She discarded the expired insulin, and she obtained two new pens of insulin and placed them in the cart for use. She said most insulins were to be replaced 28 days after opening. She said all insulins should have an open date on them since they were only good for so many days after opening. She said the number of days depended on the insulin. She said if a resident was given medications that were expired, the medications may not provide an effective result. She said the nurses and medication aides were responsible for ensuring their carts did not have expired medications. She said going forward she would provide education on multi-dose vial usage and more frequent monitoring of the medication carts for expired medications. During an interview on 12/09/2025 at 2:30 PM, the Administrator said the DON was responsible for ensuring medications were labeled and stored as required by regulations. She said she expected all expired medications to be removed from medication carts. The Administrator said if a resident was given medications that were expired, the medications may not provide an effective result. Record review of a facility policy titled Vials and Ampules of Injectable Medications Storage of Medications in the Home, dated 09/2018, with revision date 09/2020 indicated: Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use, and disposal. Nursing policies developed by the facility may supersede the procedures outlined in this policy. 1. Vials and ampules dispensed by the pharmacy are maintained in the box or container with the pharmacy label in which they are dispensed. 2. Unopened vials expire on the manufacturer's expiration date. Opening a vial triggers a shortened expiration date that is unique for that product. The date opened and this triggered expiration date are both important to record on multi-dose vials. At a minimum, the date opened must be recorded. These labels are not required on single-use vials or ampules. Triggered expiration dates may be found in the manufacturer's package insert, on the package provided, or on a reference chart by the pharmacy, or by contacting the pharmacist. 3. Ampules and single-use vials (containing no preservative) are discarded immediately after use. 4. The solution in multi-dose vials (MDV) is inspected prior to each use for unusual cloudiness, precipitation, (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or foreign bodies. The rubber stopper is inspected for deterioration. If an MDV is opened and does not indicate the date opened, the date opened reverts to the date of dispensing on the container, and the use period is determined from that date. If the dispensing date cannot be determined, the product should not be used and should be discarded according to the facility's policy.5. If an unused/unopened multi-dose vial shows visible evidence of precipitation or contamination or the rubber stopper is deteriorating, it is not to be used but should be returned to the provider pharmacy. A replacement vial is ordered from the provider pharmacy. The pharmacy provider determines the need for reporting a defective solution to the manufacturer and/or filing a Drug Product Problem Report with the Food and Drug Administration (FDA) MedWatch program.6. Medication in multi-dose vials may be used until the manufacturer's recommended expiration date if inspection reveals no problems during that time. USP <797> guidelines recommend discarding multi-dose vials 28 days after opening. The date opened and the triggered expiration date should be recorded on a label for such purpose affixed to the vial. Expiration date triggered by opening should be available either in the manufacturer's labeling or package insert, on a chart provided by the pharmacy, or from the pharmacist.Record review of the package insert for Lantus Solostar (insulin aspart flex pen) accessed at https://www.lantus.com .pdf on 12/08/25 indicated unopened and stored at room temperature was good for 28 days, unopened and refrigerated was good until the expiration date, and opened was good for 28 days.Record review of the package insert for insulin glargine (insulin flex pen) accessed at https://insulins.lilly.com on 12/08/25 indicated unopened and stored at room temperature was good for 28 days, unopened and refrigerated was good until the expiration date, and opened was good for 28 days.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 3 medication carts (nurse cart for 300 hallway) reviewed for labeling and storage. The facility did not document when insulin was opened from the nurse medication cart for the 300 hallway. These failures could place residents who receive medications at risk of not receiving the intended therapeutic benefit of the medications, decreased quality of life, and hospitalization. Findings included: Record review of the Physician Summary of orders dated 12/09/2025 indicated Resident #48 was a [AGE] year-old male admitted on [DATE]. His diagnosis included type 2 diabetes. An order dated 05/03/2025 indicated Resident #48 was to have Insulin Aspart Flex pen 100 unit/millimeter (Insulin) solution Inject as per sliding scale (amount of insulin given per level of blood sugar at time of testing): if 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 and greater notify physician, before meals subcutaneously for Type 2 Diabetes. Record review of the Physician Summary of orders dated 12/09/2025 indicated Resident #48 had an order dated 11/25/2025 for Lantus Solostar Subcutaneous Solution Pen-injector 100 unit/millimeter (Insulin Glargine) Inject 25 unit subcutaneously in the morning related to type 2 Diabetes. During an observation of the nurse medication cart for the 300 hall on 12/08/2025 at 10:45 AM with LVN C revealed the following: Lantus Solostar Solution 100 unit per milliliter flex pen with no open date documented on label or container, with an issue from pharmacy date of 11/26/2025. Pharmacy directions indicated to discard medication 28 days after the open date. During an interview on 12/08/2025 at 09:00 AM, the DON said she did not know the medication cart had unlabeled insulins (no date when opened). She discarded the unlabeled insulin, and she obtained a new pen of insulin and placed it in the cart for use. She said most insulins were to be replaced 28 days after opening. She said all insulins should have an open date on them since they were only good for so many days after opening. She said the number of days depended on the insulin. She said if a resident was given medications that were expired, the medications may not provide an effective result. She said the nurses and medication aides were responsible for ensuring their carts did not have expired medications. She said going forward she would provide education on multi-dose vial usage and more frequent monitoring of the medication carts for expired medications. During an interview on 12/09/2025 at 2:30 PM, the Administrator said the DON was responsible for ensuring medications were labeled and stored as required by regulations. She said she expected all insulins and multi-dose vials to be dated when opened and expired medications to be removed from medication carts. The Administrator said if a resident was given medications that were expired, the medications may not provide an effective result. Record review of a facility policy titled Vials and Ampules of Injectable Medications Storage of Medications in the Home, dated 09/2018, with revision date 09/2020 indicated: Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use, and disposal. Nursing policies developed by the facility may supersede the procedures outlined in this policy. 1. Vials and ampules dispensed by the pharmacy are maintained in the box or container with the pharmacy label in which they are dispensed. 2. Unopened vials expire on the manufacturer's expiration date. Opening a vial triggers a shortened expiration date that is unique for that product. The date opened and this triggered expiration date are both important to record on multi-dose vials. At a minimum, the date opened must be recorded. These labels are not required on single-use vials or ampules. Triggered expiration dates may be found in the manufacturer's package insert, on the (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	package provided, or on a reference chart by the pharmacy, or by contacting the pharmacist.3. Ampules and single-use vials (containing no preservative) are discarded immediately after use.4. The solution in multi-dose vials (MDV) is inspected prior to each use for unusual cloudiness, precipitation, or foreign bodies. The rubber stopper is inspected for deterioration. If an MDV is opened and does not indicate the date opened, the date opened reverts to the date of dispensing on the container, and the use period is determined from that date. If the dispensing date cannot be determined, the product should not be used and should be discarded according to the facility's policy.5. If an unused/unopened multi-dose vial shows visible evidence of precipitation or contamination or the rubber stopper is deteriorating, it is not to be used but should be returned to the provider pharmacy. A replacement vial is ordered from the provider pharmacy. The pharmacy provider determines the need for reporting a defective solution to the manufacturer and/or filing a Drug Product Problem Report with the Food and Drug Administration (FDA) MedWatch program.6. Medication in multi-dose vials may be used until the manufacturer's recommended expiration date if inspection reveals no problems during that time. USP <797> guidelines recommend discarding multi-dose vials 28 days after opening. The date opened and the triggered expiration date should be recorded on a label for such purpose affixed to the vial. Expiration date triggered by opening should be available either in the manufacturer's labeling or package insert, on a chart provided by the pharmacy, or from the pharmacist. Record review of the package insert for Lantus Solostar (insulin aspart flex pen) accessed at https://www.lantus.com .pdf on 12/08/25 indicated unopened and stored at room temperature was good for 28 days, unopened and refrigerated was good until the expiration date, and opened was good for 28 days. Record review of the package insert for insulin glargine (insulin flex pen) accessed at https://insulins.lilly.com on 12/08/25 indicated unopened and stored at room temperature was good for 28 days, unopened and refrigerated was good until the expiration date, and opened was good for 28 days.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain and ensure safe and sanitary storage of residents' food items for 1 of 4 resident's personal refrigerators reviewed for food safety (Resident #59).The facility failed to ensure the refrigerator for Resident #59 did not contain a bottle of Miracle Whip that expired on 9/23/2025. This failure could place residents at risk for food borne illnesses. Findings included:Record review of an admission Record for Resident #59 dated 12/9/2025 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of congestive heart failure (heart's inability to pump effectively), COPD (a group of lung disease that affect breathing), type 2 diabetes, and fusion of spine (a surgical procedure that permanently connects to or more bones in the spine).Record review of a Quarterly MDS Assessment for Resident #59 dated 11/28/2025 indicated she had moderate impairment in thinking with a BIMS score of 12. She required partial/moderate assistance with personal hygiene, which the helper does less than half the effort. She was always incontinent of urine/bowel.Record review of a care plan for Resident #59 dated 10/10/2025 and revised on 10/14/2025 indicated she had an ADL self-care performance deficit and was at risk for not having her needs met in a timely manner. Interventions included for toileting: extensive assistance. There was no record to indicate the resident would not allow staff to check her personal refrigerator.During an observation and interview on 12/8/2025 at 10:15 AM, Resident #59 was in bed awake. She had a personal refrigerator that had a bottle of Miracle Whip that expired 9/23/2025. Resident #59 was asked about the bottle of Miracle Whip and said she had not used it in a long time and was not aware it was expired.During an observation and interview on 12/9/2025 at 2:39 PM, Resident #59's personal refrigerator still had the bottle of expired Miracle Whip. She said the lady that just brought her ice water was the person who checked her refrigerator daily. She said she ate food out of her refrigerator and did not know the Miracle Whip was expired. During an observation and interview on 12/9/2025 at 2:40 PM, MA D said she had been employed at the facility since 2019 and was told recently in November 2025 that she would be responsible for checking the personal refrigerators once during the shift, and all the MA's were responsible. She said they checked the temperatures and was not told to check the refrigerators for expired or old foods. She observed the refrigerator for Resident #59 and removed the bottle of miracle whip. She said residents could get sick or get food poisoning from eating foods that expired.During an interview on 12/10/2025 at 11:32 AM, the DON said all the department heads in the facility conducted angel rounds with each resident in the facility and they checked the personal refrigerators. She said they checked for cleanliness, temperatures of the refrigerators and expiration dates of food items daily. She said the medication aides in the facility checked the temperatures and logged them daily. She said residents could get sick if they ate food that was beyond the expiration date. During an interview on 12/10/2025 at 11:47 AM, the BOM said she conducted angel rounds daily and Resident #59 was one of the rooms she checked daily. She said she checked the personal refrigerators for temperatures, spills, and expired food items. She said Resident #59 would not allow staff to clean her refrigerator and Resident #59 would tell her she would do it herself. She said she had tried many times in the past, but the resident will not allow her to check her refrigerator. She said she was not aware she had a bottle of miracle whip that had expired. She said if residents ate food items that were expired, they could get sick.During an interview on 12/10/2025 at 2:30 PM, the Administrator said the staff and resident families helped with monitoring of the personal refrigerators. She said the MA's checked the temperatures daily. She said the department heads conducted angel rounds daily and they checked the refrigerators for expired food items. She said the BOM had told her before that Resident #59 did not like for the staff to remove items from her refrigerator. She said she would have the MA's help to monitor the refrigerators going forward for expired food. She said residents could be at risk of illnesses if they ate food that expired.Record review of a facility policy titled Resident Refrigerators (continued on next page)		

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

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revised 8/23/2023 indicated, .This facility does not provide a refrigerator in a resident's room. However, it is the policy of this facility to ensure safe and sanitary use of any resident-owned refrigerators. 3. Staff shall inspect the refrigerator weekly, clean as needed, and discard any foods that are out of compliance. b. Foods with use-by dates shall be discarded accordingly .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 6 residents (Resident #59) reviewed for infection control. The facility failed to ensure staff did not place dirty towels on the floor of Resident #59's bathroom from 12/8/2025 to 12/9/2025. This failure could place residents at risk for cross contamination and infection. Findings included: Record review of an admission Record for Resident #59 dated 12/9/2025 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of congestive heart failure (heart's inability to pump effectively), COPD (a group of lung disease that affect breathing), type 2 diabetes, and fusion of spine (a surgical procedure that permanently connects to or more bones in the spine). Record review of a Quarterly MDS Assessment for Resident #59 dated 11/28/2025 indicated she had moderate impairment in thinking with a BIMS score of 12. She required partial/moderate assistance with personal hygiene, which the helper does less than half the effort. She was always incontinent of urine/bowel. Record review of a care plan for Resident #59 dated 10/10/2025 and revised on 10/14/2025 indicated she had an ADL self-care performance deficit and was at risk for not having her needs met in a timely manner. Interventions included for toileting: extensive assistance. During an observation and interview on 12/8/2025 at 10:15 AM, Resident #59 was in bed awake and said she had been a resident in the facility since May or June 2025. A dirty towel was on the floor in the bathroom with a brown substance on it. Resident #59 said she had a small bowel movement that morning and the staff had cleaned her up. During an observation on 12/8/2025 2:30 PM, Resident #59 was in bed awake, and the dirty towel was still on the floor in her bathroom. During an observation on 12/9/2025 at 8:09 AM, Resident #59 was in bed awake, and the dirty towel was still on the floor in the bathroom. During an observation and interview on 12/9/2025 at 2:42 PM, CNA E went in the room of Resident #59 and observed a dirty towel on the floor. She said the nurse aides were responsible for picking up dirty linens and the dirty linens should be placed in a plastic bag. She said residents could be at risk for cross contamination and biohazard along with infection control if staff did not place the dirty linens appropriately. CNA E put gloves on her hands and picked up the dirty towel, placed it in a plastic bag, and removed it from the room. During an interview on 12/10/2025 at 11:32 AM, the DON said dirty linens should be placed in a closet in a barrel for the linens. She said linens should be bagged and not stored on the floor. She said there was a risk for infection control and harboring bacteria if dirty linens were placed on the floor. During an interview on 12/10/2025 at 2:20 PM, the Administrator said dirty linens should be placed in the dirty linen barrel in the soiled linen closet. She said whoever was handling the dirty linens was responsible for putting the dirty linens in a bag and in the barrel. She said there was a risk of infection control issues or a tripping hazard if linens were left on the floor. Record review of a facility policy titled Infection Prevention and Control Program revised 11/6/24 indicated, .This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection as per accepted national standards and guidelines. 12. Linens: a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent the spread of infection. e. Soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. Soiled linen shall not be kept in the resident's room or bathroom. f. Environmental services staff shall not handle soiled linens unless it is properly bagged		