

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/10/2025
NAME OF PROVIDER OR SUPPLIER  Whitesboro Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1204 Sherman Dr Whitesboro, TX 76273	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for 1 of 4 (Resident #1) residents reviewed for dignity. The facility failed to treat Resident #1 with dignity and promote enhancement of his quality of life when the resident was not provided a privacy bag for his urinary catheter bag (collection bag for urine) on 09/10/2025. This failure could place residents at risk of not having their right to a dignified existence maintained. Findings included: Record review of Resident #1's Face Sheet, dated 09/10/2025, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #1 had diagnoses which included benign prostatic hyperplasia (flow of urine from the bladder is blocked) and cerebral infarction (blood flow to a part of the brain is blocked). Record review of Resident #1's Quarterly MDS (tool used to assess functional capabilities and health needs) Assessment, dated 08/19/2025, reflected moderately impaired cognition with a BIMS (tool used to assess cognition) score of 08. Section H (bowel and bladder) indicated Resident #1 had an indwelling urinary catheter. Record review of Resident #1's Comprehensive Care Plan, dated 07/23/2025, reflected Resident #1 had an indwelling catheter. One intervention was position catheter bag and tubing below the level of the bladder and in a privacy bag. During an observation and interview on 9/10/2025 at 8:40 AM, Resident #1 was sitting in his wheelchair in the hallway near the nurse's station talking to CNA B. Resident #1's urinary catheter bag was hanging on his wheelchair and not in a privacy bag. Resident #1 stated it was usually covered. CNA B stated Resident #1 had probably lost the privacy bag. She stated it was supposed to be covered for the resident's dignity. CNA B stated she would get a privacy bag for the resident. During an interview on 09/10/2025 at 8:54 AM, LVN C stated Resident #1's urinary catheter bag should have been inside a privacy bag. She stated it was a dignity issue. During an interview on 09/10/2025 at 2:14 PM, the DON stated her expectation was for nursing staff to ensure urinary catheter bags were covered for the dignity of the residents. During an interview on 09/10/2025 at 3:20 PM, the ADON stated residents with a urinary catheter should have it in a privacy bag for the resident's dignity. The facility's policy Catheter Care, undated, did not address the use of a privacy bag.</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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NAME OF PROVIDER OR SUPPLIER  Whitesboro Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1204 Sherman Dr Whitesboro, TX 76273	
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 of 10 (Resident #2) residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #2's room was in a position accessible to the resident on 09/10/2025. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings included: Record review of Resident #2's Face Sheet, dated 09/10/2025, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #2 had diagnoses which included dementia (decline in cognitive function that interferes with daily life) and unsteadiness on feet. Record review of Resident #2's Quarterly MDS Assessment, dated 08/20/2025, reflected severe cognitive impairment with a BIMS score of 03. Resident #2 required staff assistance for self-care needs. Record review of Resident #2's Comprehensive Care Plan, dated 09/01/2025, reflected the resident was at risk for falls. One of the interventions was to ensure the call light was within reach and encourage the resident to use it for assistance as needed. During an observation and interview on 09/10/2025 at 9:40 AM, Resident #2 was lying in bed awake. Resident #2's call light cord was on the floor approximately two feet to the right of the head of his bed. When he was asked if he used his call light, Resident #2 replied no. A further attempt to interview the resident was unsuccessful due to his cognitive status. CNA B came into the resident's room and stated the resident did not use the call light. He stated Resident #2 had poor vision and the call light was normally clipped near the resident's pillow. CNA B placed the call light within the resident's reach. He stated it was important for the call light to be within the resident's reach so he could use it to call for help. During an interview on 09/10/2025 at 10:23 AM, LVN C stated Resident #2 did not use the call light and staff had to anticipate his needs. She stated staff tried to keep the call light clipped on Resident #2's bed. She stated it was important to ensure the call light was within the resident's reach because it was a safety issue. LVN C stated it was also Resident #2's right to have access to his call light. During an interview on 09/10/2025 at 1:45 PM, the Administrator stated the facility did not have a policy specific to call light placement. He stated the expectation was for all residents to have access to their call lights. He stated the nursing staff monitored call light placement during rounds, and all staff should ensure the call light is within reach before leaving a resident's room. He stated the call light should have been clipped within Resident #2's reach. During an interview on 09/10/2025 at 2:14 PM, the DON stated Resident #2's call light should have been within his reach so if he wanted to use it he could. During an interview on 09/10/2025 at 3:20 PM, the ADON stated all residents should have their call light in reach. He stated it was for the residents' safety and to ensure they could notify staff if they needed assistance of any kind. The facility did not provide a policy related to the use of call lights.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 5 (Resident #3) residents reviewed for infection control. The facility failed to ensure CNA B changed gloves and washed his hands while providing incontinence care for Resident #3 on 09/10/2025. This failure could place residents at risk of cross-contamination and development of infections. The findings included: Record review of Resident #3's Face Sheet, dated 09/10/2025, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #3 had diagnoses which included hypertension (high blood pressure) and chronic obstructive pulmonary disease (lung disease that causes shortness of breath). Record review of Resident #3's Quarterly MDS Assessment, dated 08/04/2025, reflected intact cognition with a BIMS score of 15. Section H (bladder and bowel) indicated Resident #3 was frequently incontinent of bowel and bladder. Record review of Resident #3's Comprehensive Care Plan, dated 06/26/2025, reflected Resident #3 has bladder incontinence. Interventions included to provide incontinence care as needed every two hours and monitor for signs and symptoms of a urinary tract infection. During an interview and observation on 09/10/2025 at 1:20 PM, CNA B provided incontinence care for Resident #3. Resident #3 agreed for the surveyor to observe CNA B provide care. CNA B washed his hands in the resident's restroom and placed incontinence care items on a towel draped over the bedside table. CNA B pulled down the front of the brief and cleaned the resident used a single wipe for each pass. CNA B removed his gloves and went to a cabinet in the resident's room, opened the door, and removed a clean brief. CNA B did not use hand sanitizer or wash his hands. CNA B returned to the bedside and put on clean gloves. Resident #3 rolled to her left side and CNA B cleaned the resident's bottom. He did not remove his gloves. CNA B placed the clean brief under Resident #3. He moved to the opposite side of the bed and Resident #3 rolled to her right side. CNA B pulled on the draw sheet to straighten it and straightened the brief under the resident. Resident #3 rolled to her back and CNA B secured the tabs on the brief. CNA B removed his gloves and washed his hands in the resident's restroom before exiting the room. CNA B stated he should have washed his hands or used hand sanitizer when he took off his gloves. CNA B stated he should not have touched the clean brief and draw sheet while wearing the gloves he used to clean Resident #3. CNA B stated it could spread infectious diseases. During an interview on 09/10/2025 at 2:02 PM, LVN C stated anytime a staff member removed gloves, they should wash their hands or use hand sanitizer. LVN C stated staff should not touch anything else with soiled gloves. She stated it was important for infection control. During an interview on 09/10/2025 at 2:14 PM, the DON stated the expectation of staff was to always wash their hands or use hand sanitizer between dirty and clean gloves. She stated this was important because of the potential for infection. She stated the facility would provide in-service training to ensure staff followed infection control measures when caring for residents. During an interview on 09/10/2025 at 3:20 PM, the ADON stated CNA B should have washed his hands or used hand sanitizer when changing gloves during incontinence care. He stated CNA B should not have touched clean items while wearing soiled gloves. The ADON stated it was important to prevent cross contamination and infection. Review of the facility's policy Fundamentals of Infection Control Precautions, undated, reflected, A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene . Before and after assisting a resident with personal care. Wearing gloves does not replace the need for hand washing because gloves may have small inapparent defects or be torn during use, and hands can become contaminated during removal of gloves.</p>		