

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 10/22/2025
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 (Resident #1) of 5 residents reviewed for accidents and hazards. The facility failed to ensure Resident #1 did not break the window in her room, exit the window, and walk to the staff smoking area where she was found lying on a bench on 10/20/2025 at 8:10 PM, approximately 30 minutes after she was noted to be missing. The non-compliance was identified as PNC (Past Non-Compliance) on 10/22/2025 and the IJ template was provided to the facility on [DATE] at 3:21 PM. The noncompliance began on 10/20/2025 and ended 10/21/2025. The facility corrected the non-compliance before the survey began. This failure could place the residents at risk of serious harm, injury and death from wandering outside the facility in unfamiliar surroundings. Findings include: Record review of the facility reported incident, dated 10/20/2025, reflected Resident #1 broke her window and exited the building on 10/20/2025. Record review of Resident #1's Face Sheet, dated 10/22/2025, reflected the resident was an [AGE] year-old who admitted [DATE]. Resident #1 had diagnoses which included dementia (decline in cognitive function that interferes with daily life), bipolar disorder (extreme mood swings, including emotional highs and lows), and delusional disorders (false beliefs that are resistant to reasoning or contrary evidence). Record review of Resident #1's Comprehensive Care Plan, dated 10/21/2025, reflected The resident is at risk for wandering. Date initiated 07/13/2024. Interventions included to identify the pattern of wandering and intervene as appropriate; if the resident is exit seeking, stay with the resident and notify the charge nurse by calling out, sending another staff member, or using the call system; offer pleasant diversions, structured activities, food, conversation, television, or a book. Record review of Resident #1's Comprehensive Care Plan, dated 10/21/2025, reflected Actual elopement or elopement attempt. Resident left the facility unattended. Interventions included Supervise closely with increased staff monitoring x 72 hours or until further guidance. Begin with one-one-one monitoring. Dated Initiated: 10/20/2025. Determine the reason the resident is attempting to elope. Is the resident looking for something or someone Does it indicate the need for more exercise? Intervene as appropriate. Date Initiated: 10/20/2025 . Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. Date initiated: 10/20/2025. Distract resident from elopement attempts by offering pleasant diversions, structured activities, food, conversation, television, books. Date Initiated 10/20/2025. Record review of Resident #1's clinical file on 10/22/2025 reflected no prior attempt to elope. Record review of Resident #1's Quarterly MDS (tool used to assess health status) Assessment, dated 09/25/2025, reflected severely impaired cognition with a BIMS (screening tool to assess cognitive status) score of 07 and indicated no behavioral symptoms. Resident #1 was ambulatory with a walker and independent with most activities of daily living. Record review of RN A's Event Nurses' Note, dated 10/20/2025, indicated Resident #1 exited through a window and was located 30 minutes after she was noted to be missing on the bench in the gated area of the garden. Resident #1 told staff she heard the [NAME] talking. Resident #1 was assessed, and vital signs were taken. She sustained no injury. Resident #1 was transported to the hospital for further evaluation. Record review of RN A's progress note, dated 10/20/2025, reflected Resident broke out window and crawled out. Was found on the bench in the fenced area of the garden lying on a bench with head covered with cowboy hat eyes closed. When approached and called by name opened eyes and answered all questions appropriately. Refused to sit up at that time. When asked what happened, Resident stated, 'Matt was talking to me the ARC Angel.' Taken by ambulance to hospital for evaluation at this time. An attempt to interview RN A by telephone on 10/22/2025 was unsuccessful. During an observation and interview on 10/22/2025 at 9:42 AM, the Administrator stated at 8:30 PM on 10/20/2025, he received a phone call notifying him Resident #1 had busted her bedroom window and got out of the building. He stated the charge nurse had looked in Resident #1's room a few minutes earlier and the resident was looking through her dresser drawers. The nurse went to give medication to another resident. When the nurse returned to Resident #1's room, she was not in her room, bathroom or closet. The nurse noticed the glass window was broken and alerted the staff to search for her. The Administrator stated a CNA located her outside in the smoking area lying on a bench. He stated Resident #1 told staff [NAME] said the building was on fire and she broke the window and got out. He stated Resident #1 was assessed and she had no cuts or injury. Resident #1 refused to go back inside the building with staff. He stated emergency medical services was called, came and assessed the resident, and</p>		