STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675856	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitesboro Health and Rehabilitation Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for two of ten residents (Resident #1 and Resident #2) reviewed for abuse and neglect.The facility failed to ensure Resident #1 was free from abuse when Resident #2 hit him on 01/04/2026. This failure could place residents at risk of abuse and emotional stress.The findings include:Record review of Resident #1's Face Sheet, dated 01/30/2026, reflected the resident was a [AGE] year-old male who admitted on [DATE]. Resident #1 had diagnoses which included Alzheimer's disease (loss of memory and cognitive ability that interferes with daily life) and unspecified psychosis (the person has trouble differentiating between what is real and what is not). Resident #1 resided in the memory care unit. Record review of Resident #1's Quarterly MDS (tool used to assess health status) Assessment, dated 12/11/2025, reflected severely impaired cognition with a BIMS (screening tool to assess cognitive status) score of 05. Section E (Behavior) indicated the resident wandered daily. It did not reflect other behaviors. Section GG (Functional Abilities) reflected the resident required assistance with self-care and mobility needs. Record review of Resident #1's Comprehensive Care Plan, dated 11/24/2025, reflected The resident has impaired cognitive function/dementia or impaired thought processes. Interventions included The resident understands consistent, simple, directive sentences. Engage the resident in simple, structured activities that avoid overly demanding tasks. Use task segmentation to support short term memory deficits. Resident #1's Comprehensive Care Plan did not indicate behaviors toward staff or other residents. Record review of Resident #2's Face Sheet, dated 01/30/2026, reflected the resident was an [AGE] year-old male who originally admitted on [DATE] and re-admitted on [DATE]. Resident #2 had diagnoses which included dementia (decline in cognitive function that interferes with daily life), schizophrenia (mental health disorder that affects how a person thinks, feels, and behaves), and bipolar disorder (extreme mood swings, including emotional highs and lows). Resident #2 resided in the memory care unit. Record review of Resident #2's Quarterly MDS, dated [DATE], reflected severely impaired cognition with a BIMS score of 00. Section E (Behavior) reflected Resident #2 did not have any behavioral symptoms. Section GG (Functional Abilities) indicate Resident #2 required assistance with self-care and mobility needs. Record review of Resident #2's Comprehensive Care Plan, dated 11/24/2025, reflected the resident has potential to demonstrate physical behaviors. Interventions included Medication review and labs as necessary and Minimize resident's disruptive behaviors by offering tasks which divert attention.Record Review of LVN E's Progress Note, dated 11/21/2025, reflected Resident #2 was agitated with the aide who was trying to get another resident out of bed. The resident was directed to his room to decrease stimulation. Record review of LVN E's Progress Note, dated 01/02/2026, reflected Resident #2 swung at a staff member and another resident. Resident #2 was directed to a different room and given food. Interventions included direct to the resident's room to (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	decrease stimulation and provide music or sensory stimulation.Record review of LVN E's Progress Note, dated 01/04/2026, reflected CNA F informed him Resident #1 was sitting on the couch and Resident #2 hit him. No injury was noted. The residents were separated and Resident #2 had one-on-one staff monitoring. Record review of the DON's Progress Note, dated 01/05/2026, reflected the psych nurse practitioner adjusted Resident #2's medication and the resident remained on one-one-one supervision. Record review of the facility-provided monitoring logs reflected Resident #2 had one-on-one monitoring on 01/04/2026 and 01/05/2026. He had q15 minute monitoring from 01/06/2026 until he discharged on 01/08/2026.During an interview on 01/30/2026 at 9:39 AM, CNA A stated she had cared for Resident #2 since he admitted to the facility. She stated Resident #1 like to talked constantly and Resident #2 did not like it. She stated she never saw Resident #1 or Resident #2 hit anyone. CNA A stated Resident #2 did swing at her one time. She stated she was trying to get him to sit down in a chair. She stated the chair did not have arms and Resident #2 felt like he was falling if a chair did not have arms to grab. She stated the main thing with Resident #2 was how you approached him. She stated other staff had said he tried to hit them when they provided care. She said if he was upset, give him a few seconds before you re-approached, and he was fine. During an interview on 01/30/2026 at 9:50 AM, CNA B stated when she started working on the memory care unit, she was told to watch Resident #2 because he might try to hit her. She stated Resident #2 never tried to hit her, and she did not have to intervene to keep him from hitting another resident. She stated staff had in-service training on resident abuse and resident altercations. She stated if residents had an altercation, staff would separate, re-direct and get residents interested in something else, or take their hand and walk with them. She said Resident #1 liked to get up and wander, and she walked with him. She stated Resident #1 did not bother anyone. He knocked on residents' doors and tried to talk with them. During an interview on 01/30/2026 at 10:04 AM, Resident #1 was lying on his bed watching television. When asked if he felt safe at the facility, he replied Oh, yes. He replied, No when asked if he was afraid of anyone. When asked if another resident had ever hit him, he replied not that I can think of. Resident #1 stated he would not let anyone hit him. During an interview on 01/30/2026 at 10:44 AM, LVN C stated she worked the day shift on the memory care unit. She stated she was not working at the time of the incident involving Resident #1 and Resident #2. She stated Resident #2 had his moments but she never saw him hit anyone. She stated he would yell for other residents to get out of his room. She stated the CNAs had not reported to her that Resident #2 hit a resident. She stated the facility had recent in-service training on abuse, neglect, and resident altercations. She stated they also had online training. An interview attempt with CNA F on 01/30/2026 at 10:57 AM was unsuccessful.An interview attempt with LVN E on 01/30/2026 at 11:05 AM was unsuccessful.During an interview on 01/30/2026 at 12:38 PM, the Administrator stated Resident #2 needed to be re-directed in the late afternoon and evening because he was unsure of what to do with himself. He stated on the day of the incident, Resident #1 and Resident #2 were in the dining room. He stated Resident #1 was not overly loud as he talked. He stated Resident #2 walked over and tapped Resident #1 on his cowboy hat he wore. He stated Resident #1 did not express pain or show a reaction. The Administrator stated based on the report he received and his own interviews, Resident #1 and Resident #2 did not remember the incident. He stated the facility initiated discharge planning at that time and Resident #2 moved to another facility. He stated Resident #2 was easily re-directed. He stated offering him a book or a drink to distract him worked great. He stated Resident #2 had not hit another resident prior to the incident with Resident #1. During an interview on 01/30/2026 at 3:29 PM, the Regional Compliance Nurse stated Resident #1 was sitting on the couch when he was hit by Resident #2. She stated she was not at the facility at (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the time, but heard Resident #2 gave Resident #1 a tap and thought it was on his arm. She opened her laptop to view his chart and stated a skin assessment was completed for Resident #1 which showed no injury. Resident #1 had a trauma informed care assessment for psychosocial wellbeing. She stated Resident #1 denied pain or feeling upset about it. She stated the staff received in-service training related to de-escalation and recognizing early warning signs. She stated Resident #2 was evaluated and his medication was adjusted. She stated Resident #2 was monitored to ensure he did not feel another resident was in his personal space. She stated Resident #2 also had a private room. She stated their secured unit was very small and staff felt Resident #2 might do better in a larger secured unit where he had more space around him. During an interview on 01/30/2026 at 12:25 PM, the Social Worker stated she spoke to Resident #1 and Resident #2 after the incident. She stated Resident #2 was sitting on the couch in the dining room looking at a book. She stated she also spoke with Resident #1. Neither resident had any memory of the incident. During a telephone interview on 02/01/2026 at 9:43 PM, LVN E stated he worked nights in the memory care unit. He stated he remembered CNA F telling him Resident #2 was sitting on the couch and Resident #1 swung at him. He stated after CNA F separated the residents and notified him; he assessed Resident #1 and Resident #2. There was no injury to either resident. He stated they kept the residents separated and continued to monitor Resident #1. He stated another incident happened a while back, but he did not remember the details. He stated he put notes in the chart about what CNA F told him at the time. He stated Resident #2 had behaviors when the aides tried to change him, but he had not hit another resident. LVN E stated the facility had in-service training related to abuse, neglect, and resident altercations. He stated when a resident was upset, it was important to talk low and calm, and to re-direct. He stated any abuse should be reported to the Administrator, who was the Abuse Coordinator. During a telephone interview on 02/02/2026 at 11:27 AM, the DON stated she was called and told Resident #2 swatted at Resident #1. She stated they were unsure if Resident #1 was hit, and on the side of caution, reported the incident. She stated Resident #1 and Resident #2 were immediately separated, and Resident #2 was placed on 1:1 monitoring. She stated a skin assessment was completed for all residents on the unit to ensure there was no unknown injury. A secured care consult was scheduled and they discussed different interventions, activities, and things Resident #2 was interested in and like to do. She stated they usually scheduled a follow up meeting, but Resident #2 had moved to a sister facility and was doing well. She stated Resident #2 was territorial and liked his space. He did not like people in his room. She stated if he saw someone do something to upset a CNA or female resident, he would stand up and stare them down, but did not get physical. She stated looking back, Resident #1 had been talking and moving things in the dining/activity room, and it probably upset Resident #1. She stated in-service training was provided to staff after the altercation. She stated the most important intervention at the time was monitoring Resident #2. She stated Resident #1 did not remember the incident when asked about it and he had no injury. During a telephone interview on 02/02/2026 at 3:25 PM, CNA F stated she was in the dining room when Resident #2 hit Resident #1. She stated Resident #1 was watching television. She stated Resident #2 walked to the sofa where Resident #1 was sitting and hit him on the right side of his head. She stated Resident #1 was wearing his cowboy hat. She stated he did not express it caused any pain. She stated Resident #2 started kicking his foot at Resident #1, but his foot did not touch Resident #1. She stated the two residents had no previous altercation. She stated Resident #2 was placed on one-to-one monitoring after the incident and moved to another facility. She stated after the incident Resident #2 did not remember what happened and Resident #1 told staff he was not hit. She said the facility had in-service training about abuse and de-escalation and to report any abuse to (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Administrator. Record review of the facility's policy Abuse/Neglect, undated, reflected The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart.Residents should not be subjected to abuse by anyone, including, but not limited to facility staff, other residents.The facility will provide and ensure the promotion and protect of resident rights. Physical abuse: Includes hitting, slapping, pinching, and kicking.