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	05/15/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50444 Based on observations, interviews, 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 one (Resident #147) of five residents reviewed for dignity. The facility failed to treat Resident #147 with dignity and promote enhancement of his quality of life when the resident was not provided a privacy bag for his foley bag (collection bag for urine) on 05/13/2025. This failure placed residents at risk of not having their right to a dignified existence maintained. Findings included: Record review of Resident #147's Face Sheet, dated 05/13/2025, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #147 had diagnoses which included obstructive and reflux uropathy (urine flow is blocked) and central cord syndrome (affects motor function in arms and legs). Record review of Resident #147's Comprehensive MDS (tool used to assess functional capabilities and health needs) Assessment, dated 05/12/2025, reflected Resident #147 was cognitively intact with a BIMS (tool used to assess cognition) score of 15. Section H (bowel and bladder) reflected Resident #147 had an indwelling foley catheter. Record review of Resident #147's Comprehensive Care Plan, dated 05/13/2025, reflected Resident #147 had an indwelling catheter related to obstructive and reflux uropathy. One intervention was to provide a catheter bag with an attached cover. During an observation, an interview on 05/13/25 at 9:34 AM, Resident #147 was sitting in his wheelchair in the doorway of his room. His foley catheter bag was not in a privacy bag. Resident #147 stated he came to the facility on Friday and a staff member told him the previous day they would bring him a bag to cover it but did not. Resident #147 stated he wanted the foley bag hid because it was embarrassing. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/13/2025 at 9:38 AM, CNA B stated she just came on shift and was going to get Resident #147 a privacy bag. She stated she planned to get one as soon as she finished rounding on her residents. She stated it was important for the resident's dignity and other residents might not want to see the foley bag. During an interview on 05/13/2025 at 9:47 AM, RN A stated the Resident #147's foley bag should have been covered. She stated it could be embarrassing for the resident. She stated no one wanted to walk around with a foley bag and have everyone see what was in it. During an interview on 5/13/2025 at 11:30 AM, the DON stated she instructed staff to get Resident #147 a foley bag with an attached cover and remind the resident to call staff to empty the foley bag. The DON stated it was important to ensure foley bags were covered for the dignity of the resident. She stated the nurses and CNAs were responsible for monitoring to ensure foley bags were covered. She stated she would in-service staff. During an interview on 05/15/2025 at 1:40 PM, the administrator stated it was important to keep the foley catheter bag in a privacy bag for the resident's dignity. He stated it could be embarrassing for the resident. Review of the facility's policy Catheter Care did not reflect the use of a privacy bag.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50444 Based on observations, interviews, and record review the facility failed to ensure the resident environment remained as free from accident hazards as possible and each resident received adequate supervision and assistive devices to prevent accidents for 1 (Resident #41) of 8 residents reviewed for accident hazards. The facility failed to ensure Resident #41's fall mat was not folded up and leaned against a wall when Resident #41 was lying in bed on 05/13/2025. This failure could place residents at risk of harm and serious injuries. Findings included: Record review of Resident #41's Physician's Order, dated 04/08/2025, reflected low bed with floor mat at bedside. Record review of Resident #41's Face Sheet, dated 05/13/2025, reflected the resident was an [AGE] year-old male who admitted to the facility on [DATE]. Resident #41 had diagnoses which included unsteadiness on feet and a history of falls. Record review of Resident #41's Quarterly MDS Assessment, dated 03/16/2025, reflected severely impaired cognition with a BIMS score of 01. The Quarterly MDS Assessment indicated that the resident had dementia and seizure (abnormal brain activity affecting muscle control) disorder. Record review of Resident #41's Comprehensive Care Plan, dated 03/31/2025, reflected Resident #41 was at risk for falls r/t Confusion, Gait/balance problem. One intervention was Keep bed in lowest position with floor mat at bedside. During an observation on 05/13/2025 at 9:26 AM, Resident #41 was lying in bed asleep. Resident #41's fall mat was folded up and leaned against the wall near his bed. During an interview on 05/13/2025 at 9:47 AM, RN A stated Resident #41 had tried to get out of bed without assistance. She stated it was important to have Resident #41's fall mat next to his bed to prevent injury if he fell . She stated she was not sure if the fall mat was to be used at nighttime or any time the resident was in bed. During an interview on 05/13/2025 at 11:30 AM, the DON stated Resident #41's fall mat should have been placed next to the bed while the resident was lying in bed. She stated it should be put up when the resident was not in bed. She stated this intervention helped prevent an injury if the resident fell . During an interview on 05/15/2025 at 1:15 PM, CNA B stated Resident #41's bed had to be in the lowest position and the floor mat next to the bed when Resident #41 was in bed. She stated this was important to prevent injury if the resident fell . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/15/2025 at 1:40 PM, the Administrator stated it was important to have a fall mat in place in case Resident #41 tried to transfer or was non-compliant with waiting for staff to assist him. He stated if the resident rolled out of the bed, the fall mat could prevent injury. The facility did not provide a policy for fall mats prior to exit.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50444 Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 2 (Resident #41 and Resident #24) of 10 residents reviewed for infection control. 1. The facility failed to ensure Resident #41's foley catheter (tube that drains urine) bag was not touching the floor when the resident was lying in bed on 05/13/2025. 2. The facility failed to ensure CNA D wiped from front to back when providing incontinent care to Resident #24 on 05/15/2025. These failures could place residents at risk of cross-contamination and development of infections. The findings included: Resident #41 Record review of Resident #41's Face Sheet, dated 05/13/2025, reflected the resident was an [AGE] year-old male who admitted to the facility on [DATE]. Resident #41 had diagnoses which included neuromuscular dysfunction of the bladder (bladder does not function properly) and hypertension (high blood pressure). Record review of Resident #41's Quarterly MDS Assessment, dated 03/16/2025, reflected severely impaired cognition with a BIMS score of 01. The MDS Assessment reflected Resident #41 had an indwelling foley catheter. Record review of Resident #41's Comprehensive Care Plan, dated 03/13/2025, reflected Resident #41 has indwelling foley catheter. Interventions included Position catheter bag and tubing below the level of bladder and in a privacy bag and check tubing for kinks and maintain drainage bag off the floor. During an observation on 05/13/2025 at 9:26 AM, Resident #41 was lying in bed asleep. Resident #41's foley bag (collects urine) was in a privacy bag and hung on the bedrail. The bottom of the privacy bag was touching the floor. During an interview on 05/13/2025 at 9:47 AM, RN A stated Resident #41's foley bag should not have been touching the floor. She stated it was not supposed to be on the floor because it could collect bacteria, become contaminated, and cause infection. During an interview on 05/13/25 at 11:30 AM, the DON stated it was important to prevent foley catheter bags from touching the ground to prevent contamination and infection. She stated the nurse and CNAs were responsible for monitoring the foley bags to ensure they were kept off of the floor. The DON stated she was in-servicing staff. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy Catheter Care reflected Be sure the catheter tubing and drainage bag are kept off the floor. Resident #24 Record review of Resident #24's Face Sheet, dated 05/14/2025, reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE]. Resident #24 had diagnoses which included dementia and the need for assistance with personal care. Record review of Resident #24's Quarterly MDS Assessment, dated 04/03/2025, reflected moderate impaired cognition with a BIMS score of 08. Section G (functional status) indicated Resident #24 required extensive assistance with toileting needs. Record review of Resident #24's Comprehensive Care Plan, dated 04/07/2025, reflected ADL Self Care Performance Deficit. One intervention was to assist resident with toileting needs. During an observation and interview on 05/15/2025 at 10:17 AM CNA D and CNA E provided incontinence care for Resident #24. CNA D and CNA E washed their hands in resident's restroom and put on gloves. CNA D pulled down the front of Resident #24's brief and used a single wipe with each pass to clean the resident, wiping in a downward motion. Resident #24 rolled to her left side and CNA E held the resident while CNA D cleaned the resident's bottom. CNA D did not wipe the resident from the front to the back, ensuring to wipe toward the bottom. After cleaning Resident #24's bottom, CNA D stated she should have wiped from front to back. CNA D did not clean the resident again. CNA D dropped the soiled brief into the trash bag. She used hand sanitizer when changing gloves. CNA D placed a clean brief under Resident #24 and applied barrier cream to the resident's bottom. CNA D used hand sanitizer when changing gloves. CNA D secured the tabs on each side of the brief and pulled up the resident's blanket. CNA D and CNA E removed their gloves and washed their hands in the resident's restroom. Upon exiting Resident #24's room, CNA D stated she should have wiped the resident from front to back to prevent infection. She stated it was important to not transfer anything. She stated not cleaning correctly could cause the resident to get a urinary tract infection. During an interview on 05/15/2025 at 11:42 AM, the DON and Regional Nurse stated it was important for staff to clean the residents properly when providing incontinence care to prevent the spread of infection. The DON stated staff would be in-serviced. Review of the facility's policy Infection Control Policy and Procedures Manual 2019, updated March 2024, reflected The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50444 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 3 (Residents #24, #23, and #1) of 12 residents reviewed for infection control. The facility failed to ensure LVN C cleaned the blood pressure cuff between residents when administering medication to Residents #24, #23, and #1 on 05/14/2025. These failures could place residents at risk of cross-contamination and development of infections. The findings included: During observation and interview on 05/14/2025 at 7:59 AM, LVN C was observed administering medication to residents. LVN C took a blood pressure cuff into Resident #24's room and checked her blood pressure prior to preparing the medication to administer. LVN C did not use a wipe to sanitize the blood pressure cuff when she returned to the medication cart. After administering the medication to Resident #24, LVN C took the blood pressure cuff into Resident #23's room and checked her blood pressure. She returned to the medication cart and did not use a wipe to sanitize the blood pressure cuff. LVN C prepared the medication and took it to Resident #23. LVN C took the blood pressure cuff into Resident #1's room to check his blood pressure. LVN C returned to the medication cart to prepare Resident #1's medication to administer. LVN C did not use a wipe to sanitize the blood pressure cuff. LVN C administered the medication to Resident #1 and returned to the medication cart. LVN C stated she did not clean the blood pressure cuff between residents. LVN C stated it was important to sanitize items used for more than one resident to control infection. During an interview on 05/14/2025 at 8:50 AM the Regional Nurse stated LVN C was probably nervous about being watched and forgot to clean the blood pressure cuff. She stated they would follow-up with LVN C. During an interview on 05/14/25 at 10:53 AM, the DON stated LVN C should have cleaned the blood pressure cuff between residents. She stated any equipment used for more than one resident must be wiped with a sanitizing wipe between residents. She stated this was important for infection control. The DON stated she had already provided 1:1 in-service to LVN C. Review of the facility's policy Infection Control Policy and Procedures Manual 2019, updated March 2024, reflected The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection .Ensure that reusable equipment is appropriately cleaned, disinfected, or reprocessed.