

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Whitney Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 101 San Marcus Whitney, TX 76692	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the resident's right to a dignified existence for 1 of 4 residents (Residents #1) reviewed for dignity. 1. The facility failed on 01/20/2026 to promote Resident #1's dignity by dressing him with 2 diaper briefs, leading to urine leakage over his clothes when he was not changed timely. 2. The facility failed on 01/20/2026 to provide Resident #1 with a change of clothes or extra toiletries when he had to be out of the facility all day for appointments. This failure placed residents at risk of embarrassment and a loss of dignity. Findings included: Review of Resident 1's quarterly MDS assessment dated [DATE] reflected a [AGE] year-old male admitted to the facility on [DATE]. He had the following diagnoses: neurogenic bladder (loss of bladder control due to nerve problems), high cholesterol, paraplegia (paralysis of the legs and lower body), psychotic disorder (severe mental disorder characterized by a dissociation from reality), schizophrenia (hallucinations, delusions, disorganized thinking or behavior), and spina bifida (birth disorder that involves the incomplete development of the spine). He had a BIMS score of 15, indicating his cognition was intact. In section H - Bladder and Bowel, he was described as always being incontinent of bowel and bladder. Review of Resident 1's undated comprehensive care plan reflected he had bowel and bladder incontinence and had a goal of being clean, dry and free from odors, with interventions of assisting with applying briefs, keeping skin clean, dry and free from odors. Resident #1 was indicated as being PASRR positive for ID & DD r/t Spina Bifida, he had a customized wheelchair and received specialized services. He was also care planned for his dx of Spina Bifida that effected his ability to care for himself with a goal of maintaining optimal mobility within his limitations, and interventions of encouraging independence in self-care when possible, providing emotional support as needed. Review of the facility's staffing sheet dated 1/20/26 reflected on Hall 2: LVN A, CNA B, CNA C, and CNA D were all assigned to work during the day, and CNA E was assigned to the night shift. In a confidential interview on 01/30/2026, who stated that Resident #1 presented to a physician's office accompanied by the TD on 01/20/2026. The interviewee stated that Resident #1's clothing was visibly soiled with urine, and Resident #1 was observed to have been wearing 2 diaper briefs under his clothes, that were both full of urine. The physician's office had to provide a pair of pants when Resident #1 left the office due to not having his own change of clothing. In an interview on 01/30/2026 at 10:08 AM with Resident #1, he stated that he remembered going to his Urology appointment wearing double briefs. He could not recall what staff member got him dressed that day. He stated that he had 2 appointments that day and was gone for a long time. He stated that he cannot go to the restroom on his own, he was incontinent and needed staff to change him. He stated that he thought his briefs were so full that day because someone made a mistake and forgot to change him. He stated he was embarrassed he had to sit in soiled clothing at the doctor's office. In an interview on 01/30/2026 at 12:15 PM with the TD, she stated that she had been transporting residents at the</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 676074	If continuation sheet Page 1 of 3

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>facility for 3 months. She stated that she recalled an appointment with Resident #1 at a Urologist's office on 01/20/2026, and that they were gone much longer than normal on that day due to him having multiple appointments She stated that when they arrived at that appointment, she could see that Resident #1's clothes were wet. She stated she had no idea Resident #1 was double briefed until the urologist appointment, which was the 2nd appointment of the day. She stated she did not know who tended to Resident #1 that morning. She stated that residents did not bring change of clothes with them, and that was the 1st time something like that had happened since she had started transporting. She stated there was almost a 3-hour time frame between the appointments, and that no other staff went with her that day. She stated that at the time she thought Resident #1 had a catheter in place. She stated that she did not have a CNA license. She stated she felt responsible to a degree for the incident due to her driving the van that was not equipped with toiletries. She stated the resident's she transported most recently were completely self-sufficient due to the van's wheelchair lift being broken. She stated she did not alert management to the incident. She stated that the doctor's office put a new brief and pair of pants on Resident #1. She stated that a negative outcome was that Resident #1 had to sit in his urine, in public, and was embarrassed. An interview was attempted on 01/30/2026 at 12:31 PM with CNA B, but the voicemail was not returned. In an interview on 01/30/2026 at 12:44 PM with LVN A, she stated that she remembered pushing Resident #1 in his wheelchair to the side door where the transportation van would have been parked. She stated the CNAs would have been responsible for getting him dressed. She stated that CNAs absolutely did not double brief residents because it was against the rules and Resident #1 had a wound on his lower back. She stated that if someone double briefed a resident, they would be doing it for reasons that were not good, such as knowing that a resident would be sitting in a brief for a long period, without being changed. She stated she was not responsible for ensuring residents had extra sets of clothes or briefs for appointments. She stated that she thought that transportation would have scheduled a CNA to go with them. She stated that Resident #1 had not been catheterized for a few months, and that it took one person to change him. She stated that Resident #1 always told staff when he needed a brief change. In an interview on 01/30/2026 at 12:58 PM with the DON, she stated that the TD was responsible for keeping the vans stocked with briefs, linens, and changes of clothes. She stated it was not practice for residents to carry a bag with personal items and changes of clothes when leaving the facility for appointments. She stated she had not done a recent in-service on resident rights or not double briefing residents. She stated it was never okay to double brief, and that double briefing would not prevent urine from leaking out. She stated that the only reason she could think someone would be double briefed was because someone thought that a person would be going for a long period of time without being changed, which was also not okay because that could cause skin breakdown. She stated Resident #1 had all-day appointments on 01/20/2026. In an interview on 01/30/2026 at 1:10 PM with the ADM, he stated that they tried to send residents out of the building in a presentable way, and if a resident was incontinent, they would try to send a CNA with them. He stated he did not recall specifically talking about Resident #1's appointment in the morning meeting to send a CNA with them. He stated that Resident #1's RP usually transported Resident #1 to appointments, but that was not the case on 01/20/2026. He stated that it would be embarrassing for a resident to sit in their own urine. An interview was attempted on 01/30/2026 at 1:19 PM with CNA D, but the voicemail was not returned. In an interview on 01/30/2026 at 4:36 PM with CNA C, she stated that she was working with CNA B on 01/20/2026. She stated she did not recall getting Resident #1 ready for his appointments that day. She stated she was working the 200 hall but that most of the time night shift staff got the residents ready for appointments,</p> <p>(continued on next page)</p>		

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