STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455475	A. Building B. Wing	02/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Settlement Nursing Center	7820 Skyline Park Dr White Settlement, TX 76108

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45054 Based on interview, observation, and record review, the facility failed to immediately consult with the resident's physician and notify the resident representative when there was a significant change in the resident's physical or mental status or need to alter treatment significantly for one (Resident #1) of eight residents reviewed for change of condition. The facility failed to notify Resident #1's physician and responsible party when the resident's blood pressure was 216/114 on 01/24/25. An Immediate Jeopardy (IJ) was identified on 02/14/25. The Administrator was notified of the Immediate Jeopardy and provided with the IJ Template on 2/14/25 at 05:04 PM. While the Administrator and DON were notified that the IJ was removed on 02/15/25 at 02:34 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place all residents at risk of not receiving immediate medical attention when there is a change in their condition, which could lead to worsening of conditions and serious injury or harm. Findings included: Record review of Resident #1's face sheet, dated, 02/04/25, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: pneumonia (infection of lungs), hypertension (high blood pressure), type II diabetes (body's inability to regulate blood sugar), muscle weakness, chronic kidney disease, morbidly obese, mild dementia (brain disorder that affects memory, thinking, and behavior). Record review of Resident #1's Quarterly MDS assessment, dated 02/03/25, revealed the resident had a BIMS score of 12 which suggested he was moderately cognitively impaired. The Quarterly MDS assessment reflected Resident #1 could usually make himself understood and could usually understand others. Further review reflected Resident #1 was dependent on staff for most ADLs. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's care plan initiated on 07/12/24 reflected the resident was diagnosed with hypertension and was at risk for fluctuations in blood pressure. Interventions included administer antihypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension (sudden drop in blood pressure when standing from a seated or prone position), headache, vertigo, chest pain, and decreased heart rate. Avoid taking blood pressure readings after physical activity or emotional distress. Monitor for edema (swelling caused by excess fluid buildup in the body's tissue) and document when present. Notify physician of changes in severity of edema as needed. Weigh at least monthly Diet as ordered. Record review of Resident #1's order summary report, dated 02/04/25, reflected the following: -Furosemide oral tablet 40 mg- give one tablet by mouth two times a day related to hypertension (active) -hydrALAZINE HCL oral tablet 25 mg-give one tablet by mouth three times a day related to hypertension. (active) - hydrALAZINE HCL oral tablet 50 mg-give one tablet by mouth three times a day related to hypertension. (active) -Lisinopril oral tablet 40 mg-give one tablet by mouth in the morning related to hypertension. (active) -Toprol XL oral tablet extended release 24-hour 25 mg-give one tablet by mouth in the morning for hypertension. Hold for SBP<110, DBP<50, pulse<50. (active) -Obtain a complete set of vitals every shift. (active) Record review of Resident #1's vitals revealed the following: 01/24/25 at 04:16 PM Blood Pressure- 216/114 taken by MA C Temperature- not documented. Further review reflected there was no blood pressure re-check documented by MA C or LVN B. Record review of Resident #1's progress notes reflected there was no documentation on 1/24/25 regarding notifying the MD or RP about the resident's elevated blood pressure. There was also no documentation by MA C that LVN B was notified of Resident #1's elevated blood pressure. Further record review of Resident #1's progress note, dated 01/25/25 at 04:37 PM by RN D, reflected the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[Resident #1] called 911 by himself that he is not feeling well, and he wants to go to hospital. Paramedics here and the writer tried to talk [Resident #1] out, to allow the facility nurse to reach the physician for orders and treatment. [Resident #1] insisted of [sic] going to the hospital. Action: [Resident #1] transported to the hospital on a stretcher by the paramedics. DON/ADON and responsible party notified. Record review of Resident #1's hospital records, dated 01/25/25, reflected the following: Chief complaint: [Resident #1] presents with fatigue from [Nursing Facility] with c/o cough and malaise (discomfort) x 3 days. Glucose 360, baseline GCS 14. Bed bound from previous CVA. . Laboratory Results: Chest X-ray - 01/25/25 -Lungs and pleura- low lung volumes. Left mid and basilar interstitial opacities (disorder that causes scarring in lung). No pleural effusion. No pneumothorax. Impression: 1. Low lung volumes. Left mid and basilar atelectasis (condition where the lower lobes of the lungs collapse) or atypical infiltrate (pneumonia). . Differential Diagnosis: Pneumonia, viral upper respiratory infection, acute on chronic CHF exacerbation. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 02/04/25 at 01:08 PM, the DON stated Resident #1 reported not feeling well on 01/25/25, and RN D was working on contacting the MD through telehealth to get orders, but the EMTs were already entering the facility after Resident #1 called 911 himself. She stated Resident #1 was transported to the hospital where he was admitted and diagnosed with pneumonia. The DON stated Resident #1's O2 level was at 92%, taken on 01/25/25 at 4:33 PM, and he likely could have been treated at the nursing facility, but he insisted on going to the hospital. The DON stated Resident #1 had a history of calling 911 if staff did not get to him quick enough, and he recently called 911 for them to come change his brief. The DON checked Resident #1's chart and stated his blood pressure was 216/114 on 01/24/25, which was considered extremely high. She stated she had not been previously made aware that Resident #1's blood pressure was elevated on 01/24/25. The DON stated with a blood pressure that high, the expectation would have been for a nurse to recheck it manually and if was still high to notify the RP and MD immediately for further instructions. She stated all blood pressures were recorded in the EHR. The DON stated Resident #1's blood pressure ran high on multiple days, and he was on routine blood pressure medication. The DON stated there were no other reports or signs indicative of Resident #1 having an infection. The DON stated not notifying the MD of an extremely high blood pressure could place the resident at risk of a stroke and any change of condition that was not assessed could lead to harm or even death. An attempted interview on 02/04/25 at 01:30 PM with RN D by phone was unsuccessful due to no response to call. In an interview on 02/04/25 at 02:03 PM, LVN A stated she worked 1st shift, Monday-Friday. She stated she worked with Resident #1 the week leading up to him going to the hospital on 01/25/25 and he did not exhibit any symptoms of respiratory distress and did not complain of being sick. LVN A stated she was surprised to find that Resident #1 was at the hospital when she returned to work on 01/27/25. In an interview on 02/04/25 at 02:25 PM, LVN B stated she worked 2nd shift, Monday-Friday. LVN B stated she worked with Resident #1 on 01/24/25 and there were no reports that he felt unwell. She stated Resident #1 was not coughing and did not have any other symptoms or complaints that day. LVN B stated Resident #1 did not have an order for daily vital checks by the nurse, so the medication aides were the only ones who checked his vitals before administering blood pressure medication. LVN B stated the medication aides were supposed to report any abnormal blood pressure readings to the nurse for them to assess and recheck. LVN B stated on 01/24/25, MA C did not report to her that Resident #1's blood pressure was higher than usual. She stated if it had been reported that Resident #1's blood pressure was 216/114, she would have rechecked it manually and notified the MD. In an interview on 02/04/25 at 02:57 PM, MA C stated she worked 2nd shift, Monday-Friday. She stated she worked with Resident #1 on 01/24/25 and checked his vitals at 04:00 PM before administering his blood pressure medication. She stated Resident #1's blood pressure was normally high when she checked it, and she would always tell the nurse. MA C stated Resident #1's blood pressure was high so often she asked the nurse about getting him a PRN blood medication to supplement his routine medication. MA C could not recall what Resident #1's blood pressure was when she checked it on 01/24/25; however, she stated if it was high, she certainly reported it to the nurse because she took her job seriously and would not forget to report something like high blood pressure, especially an extremely high blood pressure. MA C stated all blood pressure checks were supposed to be documented in the residents' EHR. MA C stated she did not normally document her communication with the nurse in the residents' EHR but moving forward she would document it in the progress notes. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview and observation on 02/04/25 at 03:45 PM, Resident #1 was dressed and well-groomed with no odors or visible marks or bruises. Resident #1 also did not show any signs of distress. Resident #1 stated he was feeling better but not completely healed since returning to the facility on [DATE] from the hospital. He stated he still had a slight cough. Resident #1 stated he called 911 himself on 01/25/25 because he had been coughing for weeks and was feeling bad on that day. Resident #1 stated he did not tell staff that he was feeling bad because he would have had to wait too long for them to call the MD so he figured it would be quicker for him to call 911 and go to the hospital. Resident #1 stated he always had a cough due to ongoing lung issues, so it was not a big deal until he started feeling worse about a day before he went to the hospital. Resident #1 stated he only told his family member that he did not feel well. Resident #1 stated he had high blood pressure and took medication for it. He stated he was unsure if his blood pressure was high on 01/24/25 or 01/25/25 but it was possible because he did not feel well in general on those days. In an interview on 02/04/25 at 03:56 PM, Resident #1's RP revealed she spoke with the resident on 01/24/25 and he told her that he did not feel well and had a cough. The RP stated the facility did not notify her of a change of condition in Resident #1 on 01/24/25; however, they called her on 01/25/25 after Resident #1 called 911 for himself and she told them to go ahead and transport him to the hospital. In an interview on 02/14/25 at 01:40 PM, the MD stated the expectation was for the nurses to notify him of any blood pressures outside of the parameters. The MD stated he was not notified on 01/24/25 that Resident #1's blood pressure was 216/114. He stated a systolic blood pressure over 180 should have been reported to him. The MD stated if it had been reported, he would have had the nurse to do a manual blood pressure re-check because the wrist cuffs were not always accurate. He stated if the blood pressure was still elevated, he would have asked for a clinical assessment of Resident #1's physical condition as the blood pressure numbers alone would not have been indicative of a hypertensive emergency. The MD stated he would have likely ordered an adjustment of the medication and monitoring unless there were concerns for Resident #1's physical condition, which he would have then ordered for the resident to be sent out to the hospital. The MD stated Resident #1 ended up going to the hospital on 01/25/25 and was diagnosed with pneumonia; however, he could not state that the elevated blood pressure the previous day was related. The MD stated the nurses usually notified him of abnormal vitals. Review of the facility's policy titled Notification of Changes, dated 07/13/2015, revealed in part the following: Policy: To provide guidance on when to communicate acute changes in status to MD, NP, and responsible party. The facility will immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or appropriate family member(s) of the following: . 3. A significant change in the physical, mental or psychosocial status of the resident. Review of an article in the American Heart Association, updated 2025, reflected in part the following: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In most cases damage from high blood pressure happens over time. If not detected and controlled, high blood pressure can lead to: -Heart attack -Stroke -Heart Failure -Kidney disease or failure . If your blood pressure reading is higher than 180/120 mm Hg, you could be having a hypertensive crisis. Wait at least 1-2 minutes and then take your blood pressure again. Contact your health care professional right away if your readings are still above 180/120 mm Hg and you aren't having any other symptoms . An Immediate Jeopardy (IJ) was identified on 02/14/25 at 03:25 PM. The Administrator and DON were notified of an Immediate Jeopardy (IJ) on 02/14/25 at 04:45 PM, due to the above failures and the IJ Template was provided at 05:04 PM. The facility's Plan of Removal (POR) was accepted on 02/15/25 at 12:46 PM and included: [Nursing Facility] 2/14/25 at 5:04pm Immediate Jeopardy called F580 Failure to Notify physician of change of condition. I. Resident Specific Staff nurse completed a clinical assessment of Resident # 1 on 2/4/25 at 5:00pm including blood pressure. Physician was immediately notified of previous high blood pressures on 2/4/25 at 5:06pm. On 2/4/25 all residents with a diagnosis of Hypertension had a clinical assessment completed by the DON and ADON including blood pressure. There were no residents identified requiring physician notification. On 2/15/25 all residents with a diagnosis of Hypertension will have a clinical assessment completed by the DON and Designee including blood pressure. Any resident identified with any abnormal findings the DON and designee will notify the physician immediately. Staff nurses will continue to monitor and report any changes to the physician. II. System Changes Each nurse will review vital signs prior to the end of their shift to ensure all abnormalities are addressed and will be ongoing. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	DON/ADON will review the previous days vital signs in morning meeting to ensure all abnormalities are addressed and will be ongoing. The weekend Supervisor will review previous days vital signs at the beginning of her shift to ensure all abnormalities are addressed and will be ongoing. III. Education On 2/4/25 medication aides were in-serviced by the ADON on reporting all abnormal vital signs to the nurse immediately and then documenting who they notified. On 2/15/25 DON completed education with all medication aides on reporting all abnormal vital signs to the nurse immediately and then documenting who they notified. This education will be ongoing to include any new staff and staff not yet trained. Identified medication aide received disciplinary action for failure to notify nurse of abnormal blood pressure. On 2/4/25 all nurses were in-serviced by DON on notifying the physician of all vital signs out of the documented parameters and documenting who they notified and what new orders were given. On 2/15/25 DON completed education with all nurses on notifying the physician of all vital signs out of the documented parameters and documenting who they notified and what new orders were given. This education is ongoing to include any new staff and staff not yet trained. IV. Monitoring DON/ADON will randomly pull 3 residents with hypertension weekly x 4 weeks and review their blood pressure for appropriate follow-up and interventions if required. Results of the random audits will be reviewed in QAPI meeting monthly x 3 months. On 02/15/25 the investigator began monitoring (01:02 PM-02:40 PM) to determine if the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy by: Observations, interviews, and records reviews on 02/15/25, 01:02 PM-01:45 PM, of Residents #1, #2, #3, #4, #5, #6, #7, and #8 revealed no further concerns for a violation of resident rights. Record review of residents' EHR reflected no concerns for changes in physical, mental, or psychosocial status. Observations and interviews with residents and/or RPs revealed no concerns for change of condition or quality of care received. Record review of Resident #1's nursing notes, dated 02/04/25, reflected the resident received a complete clinical assessment including a blood pressure check with no notable changes. Further review reflected the NP was notified of Resident #1's high blood pressures on 02/04/25, with no new orders given. Record review of a document provided by the DON titled Resident Responses Analyzer, dated 02/04/25, reflected all residents diagnosed with hypertension received a clinical assessment including blood pressure checks by the DON or ADON with no concerns requiring physician notification. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a document provided by the DON titled Resident Responses Analyzer, dated 02/15/25, reflected all residents diagnosed with hypertension received a clinical assessment including blood pressure checks by the DON with no concerns requiring physician notification. Record review of an in-service titled Abnormal vital signs and med not given, dated 02/04/25, reflected all medication aides and nurses were educated on parameters for vital signs, and when to notify the physician. Record review of an in-service titled Notification of Physician Protocol, dated 02/15/25, reflected all medication aides and nurses were educated on parameters for vital signs, and when to notify the physician. Record review of a document provided by the Administrator titled Associate Disciplinary Memorandum, dated 02/05/25, reflected MA C was disciplined for failure to notify the nurse of an abnormal blood pressure. Interviews on 02/15/25, 01:45 PM-02:40 PM, conducted with the DON, medication aides and nurses from various shifts: RN E (3rd shift/weekdays), RN D (1st shift/weekends), MA F (2nd shift/weekends), MA C (2nd shift/weekdays), LVN G (1st shift/weekends), LVN H (3rd shift/weekdays), LVN B (2nd shift/weekdays), MA I (1st shift/weekdays), and LVN J (2nd shift/weekdays). indicated they all participated in in-service trainings. The medication aides were able to describe in their own words the protocol for abnormal vital signs. They were able to state the parameters for vitals, when to notify the nurse, and to document all incidents. The nurses were able to describe in their own words the protocol for abnormal vital signs. They were able to state the parameters for vitals, to manually re-check and notify the physician as necessary, and to document all incidents. The DON stated the expectation that all vitals from the previous day would be reviewed, and any abnormal vitals would be addressed accordingly. An Immediate Jeopardy (IJ) was identified on 02/14/25. The Administrator was notified of the Immediate Jeopardy and provided with the IJ Template on 2/14/25 at 05:04 PM. While the Administrator and DON were notified that the IJ was removed on 02/15/25 at 02:34 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45054 Based on observation, interview and record review, the facility failed to ensure the residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of eight residents reviewed for quality of care. The facility failed to follow protocols for abnormal vital signs when MA C did not notify the nurse after Resident #1's blood pressure was 216/114 and there was no re-check to ensure accuracy to determine if further treatment was needed. An Immediate Jeopardy (IJ) was identified on 02/14/25. The Administrator was notified of the Immediate Jeopardy and provided with the IJ Template on 2/14/25 at 05:04 PM. While the Administrator and DON were notified that the IJ was removed on 02/15/25 at 02:34 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure placed all residents at risk of a delay in medical evaluation and treatment. Findings included: Record review of Resident #1's face sheet, dated, 02/04/25, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: pneumonia (infection of lungs), hypertension (high blood pressure), type II diabetes (body's inability to regulate blood sugar), muscle weakness, chronic kidney disease, morbidly obese, mild dementia (brain disorder that affects memory, thinking, and behavior). Record review of Resident #1's Quarterly MDS assessment, dated 02/03/25, revealed the resident had a BIMS score of 12 which suggested he was moderately cognitively impaired. The Quarterly MDS assessment reflected Resident #1 could usually make himself understood and could usually understand others. Further review reflected Resident #1 was dependent on staff for most ADLs. Record review of Resident #1's care plan initiated on 07/12/24 reflected the resident was diagnosed with hypertension and was at risk for fluctuations in blood pressure. Interventions included administer antihypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension (sudden drop in blood pressure when standing from a seated or prone position), headache, vertigo, chest pain, and decreased heart rate. Avoid taking blood pressure readings after physical activity or emotional distress. Monitor for edema (swelling caused by excess fluid buildup in the body's tissue) and document when present. Notify physician of changes in severity of edema as needed. Weigh at least monthly Diet as ordered. Record review of Resident #1's order summary report, dated 02/04/25, reflected the following: -Furosemide oral tablet 40 mg- give one tablet by mouth two times a day related to hypertension (active) (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-hydrALAZINE HCL oral tablet 25 mg-give one tablet by mouth three times a day related to hypertension. (active) - hydrALAZINE HCL oral tablet 50 mg-give one tablet by mouth three times a day related to hypertension. (active) -Lisinopril oral tablet 40 mg-give one tablet by mouth in the morning related to hypertension. (active) -Toprol XL oral tablet extended release 24-hour 25 mg-give one tablet by mouth in the morning for hypertension. Hold for SBP<110, DBP<50, pulse<50. (active) - Obtain a complete set of vitals every shift. (active) Record review of Resident #1's vitals revealed the following: 01/24/25 at 04:16 PM Blood Pressure - 216/114 taken by MA C Temperature - not documented. Further review reflected there was no blood pressure re-check documented by MA C or LVN B. Record review of Resident #1's progress notes reflected there was no documentation on 01/24/25 regarding notifying the MD or RP about the resident's elevated blood pressure. There was also no documentation by MA C that LVN B was notified of Resident #1's elevated blood pressure. Further record review of Resident #1's progress note, dated 01/25/25 at 04:37 PM by RN D, reflected the following: [Resident #1] called 911 by himself that he is not feeling well, and he wants to go to hospital. Paramedics here and the writer tried to talk [Resident #1] out, to allow the facility nurse to reach the physician for orders and treatment. [Resident #1] insisted of [sic] going to the hospital. Action: [Resident #1] transported to the hospital on a stretcher by the paramedics. DON/ADON and responsible party notified. Record review of Resident #1's hospital records, dated 01/25/25, reflected the following: Chief complaint: [Resident #1] presents with fatigue from [Nursing Facility] with c/o cough and malaise (discomfort) x 3 days. Glucose 360, baseline GCS 14. Bed bound from previous CVA. .Laboratory Results: Chest X-ray - 01/25/25 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Lungs and pleura- low lung volumes. Left mid and basilar interstitial opacities (disorder that causes scarring in lung). No pleural effusion. No pneumothorax. Impression: 1. Low lung volumes. Left mid and basilar atelectasis (condition where the lower lobes of the lungs collapse) or atypical infiltrate (pneumonia). . Differential Diagnosis: Pneumonia, viral upper respiratory infection, acute on chronic CHF exacerbation. In an interview on 02/04/25 at 01:08 PM, the DON stated Resident #1 reported not feeling well on 01/25/25, and RN D was working on contacting the MD through telehealth to get orders, but the EMTs were already entering the facility after Resident #1 called 911 himself. She stated Resident #1 was transported to the hospital where he was admitted and diagnosed with pneumonia. The DON stated Resident #1's O2 level was at 92%, taken on 01/25/25 at 4:33 PM, and he likely could have been treated at the nursing facility, but he insisted on going to the hospital. The DON stated Resident #1 had a history of calling 911 if staff did not get to him quick enough, and he recently called 911 for them to come change his brief. The DON checked Resident #1's chart and stated his blood pressure was 216/114 on 01/24/25, which was considered extremely high. She stated she had not been previously made aware that Resident #1's blood pressure was elevated on 01/24/25. The DON stated with a blood pressure that high, the expectation would have been for a nurse to recheck it manually and if was still high to notify the RP and MD immediately for further instructions. She stated all blood pressures were recorded in the EHR. The DON stated Resident #1's blood pressure ran high on multiple days, and he was on routine blood pressure medication. The DON stated there were no other reports or signs indicative of Resident #1 having an infection. The DON stated not notifying the MD of an extremely high blood pressure could place the resident at risk of a stroke and any change of condition that was not assessed could lead to harm or even death. An attempted interview on 02/04/25 at 01:30 PM with RN D by phone was unsuccessful due to no response to call. In an interview on 02/04/25 at 02:25 PM, LVN B stated she worked 2nd shift, Monday-Friday. LVN B stated she worked with Resident #1 on 01/24/25 and there were no reports that he felt unwell. She stated Resident #1 was not coughing and did not have any other symptoms or complaints that day. LVN B stated Resident #1 did not have an order for daily vital checks by the nurse, so the medication aides were the only ones who checked his vitals before administering blood pressure medication. LVN B stated the medication aides were supposed to report any abnormal blood pressure readings to the nurse for them to assess and recheck. LVN B stated on 01/24/25, MA C did not report to her that Resident #1's blood pressure was higher than usual. She stated if it had been reported that Resident #1's blood pressure was 216/114, she would have rechecked it manually and notified the MD. (continued on next page)

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	455475	A. Building B. Wing	02/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Settlement Nursing Center	7820 Skyline Park Dr White Settlement, TX 76108

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 02/04/25 at 02:57 PM, MA C stated she worked 2nd shift, Monday-Friday. She stated she worked with Resident #1 on 01/24/25 and checked his vitals at 04:00 PM before administering his blood pressure medication. She stated Resident #1's blood pressure was normally high when she checked it, and she would always tell the nurse. MA C stated Resident #1's blood pressure was high so often she asked the nurse about getting him a PRN blood medication to supplement his routine medication. MA C could not recall what Resident #1's blood pressure was when she checked it on 01/24/25; however, she stated if it was high, she certainly reported it to the nurse because she took her job seriously and would not forget to report something like high blood pressure, especially an extremely high blood pressure. MA C stated all blood pressure checks were supposed to be documented in the residents' EHR. MA C stated she did not normally document her communication with the nurse in the residents' EHR but moving forward she would document it in the progress notes. In an interview and observation on 02/04/25 at 03:45 PM, Resident #1 was dressed and well-groomed with no odors or visible marks or bruises. Resident #1 also did not show any signs of distress. Resident #1 stated he was feeling better but not completely healed since returning to the facility on [DATE] from the hospital. He stated he still had a slight cough. Resident #1 stated he called 911 himself on 01/25/25 because he had been coughing for weeks and was feeling bad on that day. Resident #1 stated he did not tell staff that he was feeling bad because he would have had to wait too long for them to call the MD so he figured it would be quicker for him to call 911 and go to the hospital. Resident #1 stated he always had a cough due to ongoing lung issues, so it was not a big deal until he started feeling worse about a day before he went to the hospital. Resident #1 stated he only told his family member that he did not feel well. Resident #1 stated he had high blood pressure and took medication for it. He stated he was unsure if his blood pressure was high on 01/24/25 or 01/25/25 but it was possible because he did not feel well in general on those days. In an interview on 02/14/25 at 01:40 PM, the MD stated the expectation was for the nurses to notify him of any blood pressures outside of the parameters. The MD stated he was not notified on 01/24/25 that Resident #1's blood pressure was 216/114. He stated a systolic blood pressure over 180 should have been reported to him. The MD stated if it had been reported, he would have had the nurse to do a manual blood pressure re-check because the wrist cuffs were not always accurate. He stated if the blood pressure was still elevated, he would have asked for a clinical assessment of Resident #1's physical condition as the blood pressure numbers alone would not have been indicative of a hypertensive emergency. The MD stated he would have likely ordered an adjusted of the medication and monitoring unless there were concerns for Resident #1's physical condition, which he would have then ordered for the resident to be sent out to the hospital. The MD stated Resident #1 ended up going to the hospital on 01/25/25 and diagnosed with pneumonia; however, he could not state that the elevated blood pressure the previous day was related. The MD stated the nurses usually notified him of abnormal vitals. Record review of the facility's policy titled Nursing Policy and Procedure (Blood Pressure-Obtaining), dated October 2020, reflected in part the following: It is the policy of this home that blood pressure readings will be obtained using correct technique to ensure accuracy. Precautions: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Report to charge nurse if blood pressure equipment is not in good working order or if cuff is not available in correct size for accurate reading. The cuff is the proper size when the length of the inflatable bladder is at least 80% of the circumference of the resident's arm. 2. Recheck a blood pressure no more than 3 times and wait at least 1 to 2 minutes before repeating the B/P measurement on the same arm. 3. Report to the charge nurse for assistance if you cannot hear the B/P or are unsure of what you are hearing after 3 tries. Do not guess at the B/P reading Record review of the facility's policy titled Notification of Changes, dated 07/13/2015, revealed in part the following: Policy: To provide guidance on when to communicate acute changes in status to MD, NP, and responsible party. The facility will immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or appropriate family member(s) of the following: .3. A significant change in the physical, mental or psychosocial status of the resident. Record review of an article in the American Heart Association, updated 2025, reflected in part the following: In most cases damage from high blood pressure happens over time. If not detected and controlled, high blood pressure can lead to: -Heart attack -Stroke -Heart Failure -Kidney disease or failure . If your blood pressure reading is higher than 180/120 mm Hg, you could be having a hypertensive crisis. Wait at least 1-2 minutes and then take your blood pressure again. Contact your health care professional right away if your readings are still above 180/120 mm Hg and you aren't having any other symptoms . An Immediate Jeopardy (IJ) was identified on 02/14/25 at 03:25 PM. The Administrator and DON were notified of an Immediate Jeopardy (IJ) on 02/14/25 at 04:45 PM, due to the above failures and the IJ Template was provided at 05:04 PM. The facility's Plan of Removal (POR) was accepted on 02/15/25 at 12:46 PM and included: [Nursing Facility] (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2/14/25 at 5:04pm Immediate Jeopardy called I. Resident Specific Staff nurse completed a clinical assessment of Resident # 1 on 2/4/25 at 5:00pm including blood pressure. Physician was immediately notified of previous high blood pressures on 2/4/25 at 5:06pm. On 2/4/25 all residents with a diagnosis of Hypertension had a clinical assessment completed by the DON and ADON including blood pressure. There were no residents identified requiring physician notification. On 2/15/25 all residents with a diagnosis of Hypertension will have a clinical assessment completed by the DON and Designee including blood pressure. Any resident identified with any abnormal findings the DON and designee will notify the physician immediately. Staff nurses will continue to monitor and report any changes to the physician. II. System Changes Each nurse will review vital signs prior to the end of their shift to ensure all abnormalities are addressed and will be ongoing. DON/ADON will review the previous days vital signs in morning meeting to ensure all abnormalities are addressed and will be ongoing. The weekend Supervisor will review previous days vital signs at the beginning of her shift to ensure all abnormalities are addressed and will be ongoing. III. Education On 2/4/25 medication aides were in-serviced by the ADON on reporting all abnormal vital signs to the nurse immediately and then documenting who they notified. On 2/15/25 DON completed education with all medication aides on reporting all abnormal vital signs to the nurse immediately and then documenting who they notified. This education will be ongoing to include any new staff and staff not yet trained. Identified medication aide received disciplinary action for failure to notify nurse of abnormal blood pressure. On 2/4/25 all nurses were in-serviced by DON on notifying the physician of all vital signs out of the documented parameters and documenting who they notified and what new orders were given. On 2/15/25 DON completed education with all nurses on notifying the physician of all vital signs out of the documented parameters and documenting who they notified and what new orders were given. This education is ongoing to include any new staff and staff not yet trained. IV. Monitoring DON/ADON will randomly pull 3 residents with hypertension weekly x 4 weeks and review their blood pressure for appropriate follow-up and interventions if required. (continued on next page)

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