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	06/17/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents were provided comfortable and safe temperature levels maintained at a range of 71 to 81 degrees Fahrenheit for 16 of 26 residents (Residents #1, #2, #3, #4, #5, #6,#7, #8, #9, #10, #11, #12, #13, #14, #15, and #16) of 26 residents reviewed for environment. The facility failed to ensure Residents #1, #2, #3, #4, #5, #6,#7, #8, #9, #10, #11, #12, #13, #14, #15, and #16 had adequate cooling. This failure could place residents at risk of heat related illnesses and dehydration. Findings included: Observation on 06/17/25 at 10:00 AM of the front hallway of the facility revealed two large fans were in use in the hallway. Observation on 06/17/25 at 10:38 AM of Residents #9 and #10's room revealed there were 6 fans in use to cool the room down. The ambient temperature was 78 degrees Fahrenheit. In an interview on 06/17/25 at 10:40 AM, Resident #9 stated the air conditioning in their section of the facility had not been working for several weeks. He stated he and his roommate purchased the fans to try to keep the room cool enough to be comfortable, but it was not enough for the afternoons. Resident #9 stated after about 11:00 AM they had to stay in the common area where the air conditioning was working. The Administrator was aware and provided fans for residents. Observation and interview on 06/17/25 at 10:44 AM of Residents #5 and #6's room revealed they had two fans in use. The ambient temperature was 80 degrees Fahrenheit. Resident #6 stated the facility provided the two fans to help with the heat of the room. She stated the fans helped until around noon when the temperature was too warm to stay in the room and they had to sit in the dining area to keep cool. Observation on 06/17/25 at 10:48 AM of Residents #1 and #2's room revealed an ambient temperature was 75 degrees Fahrenheit. Both residents were not in their room. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 06/17/25 at 10:52 AM of Resident's #3 and #4's room revealed two fans were in use. The ambient temperature was 75 degrees Fahrenheit. Resident #3 stated the room was comfortable as long as she had her fans on. Her family purchased the two fans in use. Observation on 06/17/25 at 11:00 AM of Residents #7 and #8's room revealed two fans were in use. Both residents were not in their room. The ambient temperature was 76 degrees Fahrenheit. Observation and interview on 06/17/25 at 11:04 AM of Residents #11 and #12's room revealed two fans were in use. Resident #12 stated she purchased the fans for the heat. She spent the afternoons in the dining area where it was cooler. The ambient temperature was 77 degrees Fahrenheit. Observation and interview on 06/17/25 at 11:10 AM of Residents #13 and #14's room revealed two fans in use. The ambient temperature was 75 degrees Fahrenheit. Resident #13 stated the room was still too uncomfortable to spend much time in. Resident #13 had sweat on his forehead. Observation and interview on 06/17/25 at 11:20 AM of Residents #15 and #16's room revealed three fans were in use. Resident #15 stated the room was still too hot even with the fans. Her roommate spent all day in the dining area where it was cool, and she herself would go out there when it got to be too much. She stated her hair was wet from sweat, and her hair appeared damp at the nape of the neck. The ambient temperature was 76 degrees Fahrenheit. In an interview on 06/17/25 at 11:40 AM, the Maintenance Director stated Unit #3 covered rooms 15-22 and it was serviced by their HVAC company two weeks prior when the elevated temperature was noticed in that area. He stated the company got the unit working again by bypassing something but it was still not cooling enough. The company was supposed to be back with an ordered part to complete the process. He stated the temperature should be between 72 and 74 degrees for the comfort of the residents. He stated if it was too hot the residents could be at risk of heat related illnesses. Follow up observations on 06/17/25 from 12:30 PM-12:50 PM of Rooms 15-22 revealed the temperatures had risen even higher. room [ROOM NUMBER] was measured at 79 degrees, room [ROOM NUMBER] was measured at 77 degrees, room [ROOM NUMBER] was measured at 82 degrees, room [ROOM NUMBER] was measured at 81 degrees, room [ROOM NUMBER] was measured at 80 degrees,, room [ROOM NUMBER] was measured at 79 degrees, room [ROOM NUMBER] was measured at 79 degrees, and room [ROOM NUMBER] was measured at 80 degrees. The ambient temperature in the hallway was 80 degrees Fahrenheit as measured with ambient thermometer by the Surveyor. In a phone interview on 06/17/25 at 3:10 PM the Administrator stated HVAC unit #3 had been struggling to keep up. The HVAC company advised there was not enough return air for the unit to function properly. They recommended placing portable units in the dining area next to the affected area, blocking off the vents in the dining area to attempt to divert enough flow to the affected rooms. She stated she was waiting to hear from corporate on what they were going to do. She stated the biggest risk to the residents was dehydration. She was still waiting to hear back from the corporate office on how they were going to proceed. The Administrator stated staff were keeping the affected residents supplied with ice and water. Record review of the facility's policy Homelike Environment, dated 4/24/25, reflected: 1. Living spaces (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	. Ensure that living spaces are comfortable, safe, and accessible, with appropriate lighting, temperature control and furniture.

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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 interviews and record reviews, the facility failed to ensure residents had the right to be free from abuse , neglect, misappropriation of resident property, and exploitation for 2 of 4 residents (Residents #17 and #18) reviewed for abuse. The facility failed to ensure Resident #17 was not abused by Resident #18 who hit her in the face. The noncompliance was identified as PNC. The noncompliance began on 05/22/25 and ended on 05/22/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of injury and loss of dignity. Findings included: Record review of Resident #17's undated admission Record reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included dementia, bipolar disorder, and schizoaffective disorder. Record review of Resident #17's quarterly MDS, dated [DATE], reflected a BIMS score of 8, which indicated moderate cognitive impairment. Record review of Resident #17's care plan, dated 03/31/25, reflected she had impaired judgement related to her cognitive decline, and she had behavioral problems of going into other resident's closets and taking items that did not belong to her. Record review of Resident #17's assessment on 05/22/25 by RN A reflected: This nurse got notified that there was yelling between two residents about purse. The two residents [Resident #18] and [Resident #17] pulling purse from one another, physical therapy staff and nurse got separated them. Upon head to toe assessment, no pain/injury noted at this time. Resident walking with walker, alert and oriented. MD, Administrator, DON made aware. Unable to reach RP .voice message left. Record review of Resident #18's undated admission Record reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included kidney failure, diabetes, and cognitive communication deficit. Record review of Resident #18's quarterly MDS reflected a BIMS score of 14, indicating she was cognitively intact. Record review of Resident #18's care plan, dated 05/15/25, reflected she had behavioral problems related to her schizophrenia, and impaired visual function related to her vision decline. The resident's care plan had also been updated for her aggressive behavior on 05/22/25. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's investigation report reflected on 05/22/25 around 11:15 AM the PT witnessed Residents #17 and #18 tugging on a purse, each arguing about whose purse it was. The PT stated he stepped between the two residents to break up the dispute, and as he did so Resident #18 struck out at Resident #17 with a closed fist, hitting Resident #17 in the face. The PT and other staff separated the residents and reported the incident to the DON. In an interview on 06/17/25 at 2:25 PM, the PT stated Resident #18 was working in the gym when Resident #17 entered in her wheelchair. Resident #17 had a purse and Resident #18 yelled it was her purse. Resident #18 tried to grab it from Resident #17 and a tug of war over the purse began. The PT stated he stepped between them and told Resident #17 to give the purse back. Resident #18 managed to reach around him and strike Resident #17. The PT stated it was a closed fist and she hit Resident #17 somewhere on the face. He stated there was not a lot of force to the strike. He stated he and the DOR separated the two residents. The PT took Resident #17 to the nurse station and the DOR took Resident #18 to her room with the purse. When Resident #18 looked in the purse she told the DOR it was not her purse after all. The PT reported the incident to the nurse and the DON. He did not see any redness to the resident's face. Interview attempted on 06/17/25 at 2:50 PM with Resident #17 was unsuccessful due to the resident having no recollection of the event. In an interview on 06/17/25 at 2:55 PM, Resident #18 stated she thought Resident #17 had her purse because it was the same color as hers. She stated Resident #17 had a history of taking things from her room. She said she accidentally hit Resident #17 on the head. She has had no issues since then. In a phone interview on 06/17/25 at 3:00 PM with Resident #17's Responsible Party, he stated he was told about the event. When he checked on her the next day she did not remember what happened. She had no redness or bruising to her face. He had no concerns about her care. In a phone interview on 06/17/25 at 3:05 PM with Resident #18's Responsible Party, she stated she was told about the event. She stated she was surprised Resident #18 had lashed out like that because she was usually pretty calm. She stated there did not seem to be any affects from the event, and the resident was quite happy. In an interview on 06/17/25 at 3:08 PM, the DON stated the residents resided on different halls at the time of the event, and they rarely interacted with each other. She stated Resident #17 had no recollection of the event. Staff were in-serviced on resident-to-resident altercations that day and the next day. She stated there had never been any issues between the two residents in the past, and no history of Resident #18 being aggressive towards anyone. She stated Resident #18 was very even keeled and got along with everyone, this was very abnormal for her. She stated Resident #18 stated she knew Resident #17 liked to go into other resident's rooms and take things and when she saw her with a purse that looked like hers she just got mad. She did not mean to hit the resident, she was just frustrated. The DON stated she began to in-service staff on abuse, resident altercations and how to handle aggressive residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's training records reflected an Inservice Attendance Record, dated 05/22/25, which covered: Topic: When there is are [sic] resident to resident altercation. Resdients [sic] are to be seperated [sic] immediately, assessed for any injuries, s/s of distress. Resident to resident altercations must [be] reported to the abuse coordiantor [sic] / administrator immediatly [sic]. Resident to resident altercations are considered a form of abuse and must be reported immediatly [sic] to t he abuse coordiantor [sic] / administrator. In an interview on 06/17/25 at 3:15 PM, RN A stated she was in-serviced on resident-to-resident altercations. She stated she was supposed to separate the residents, assess for injuries, and report it to the Administrator. She would then monitor the residents for continued behaviors. In an interview on 06/17/25 at 3:18 PM, LVN B stated she was in-serviced on resident-to-resident altercations. She was supposed to separate them, assess for injuries, and notify the Administrator and DON. She would then monitor the residents for continued behaviors. In an interview on 06/17/25 at 3:22 PM, MA C stated she was in-serviced on resident-to-resident altercations. She was supposed to separate the residents and report it to her nurse or the DON. She would then monitor the residents for continued behaviors. In an interview on 06/17/25 at 3:30 PM, CNA D stated she was in-serviced on resident-to-resident altercations. She stated she was to separate the residents and notify the nurse and the Administrator. She would then monitor the residents for continued behaviors. In an interview on 06/17/25 at 3:35 PM, CNA E stated she was in-serviced on altercations between residents. She stated she would separate them and notify the nurse and the Administrator. She would then monitor the residents for continued behaviors. In an interview on 06/17/25 at 3:38 PM, CNA F stated there was an in-service on resident-to-resident altercations. She was supposed to separate them and report it to the Administrator and the nurse. She would then monitor the residents for continued behaviors. Record review of the facility's Abuse, Neglect, and Exploitation policy, dated 10/24/22, reflected: .1. The facility provides resident protection that includes: a) Prevention/Prohibition resident abuse, neglect, and exploitation and misappropriation of property. .III. The facility will make every effort to prevent and prohibit all types of abuse, neglect, misappropriation of property, and exploitation The noncompliance was identified as PNC. The noncompliance began on 05/22/25 and ended on 05/22/25. The facility had corrected the noncompliance before the survey began .