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	08/11/2025

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 - Few	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. (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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(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 - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident had the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely and allowed the resident to use his or her belongings to the extent possible for 1 of 5 residents (Resident #1) reviewed for sanitary and comfortable environment.1. The facility failed to maintain Resident #1's wheelchair in a sanitary and safe operating condition leaving food, liquid, dirt, and debris to collect down both sides of the wheelchair. 2. The facility failed to ensure Resident #1's wheelchair padding on both arm rests were not torn and didn't expose padding on 08/11/25. These failures could place residents at risk of contamination, infections, skin tears and bruising. Findings include:Record review of Resident #1's Quarterly MDS, dated [DATE], reflected a [AGE] year-old female who admitted to the facility on [DATE]. Resident #1's had diagnoses which included contracture of right and left hands (a fixed tightening of muscles, tendons, ligaments, or skin that prevents normal movement of the hands), abnormalities of gait ad mobility (a walking abnormality), lack of coordination, speech disturbances (any condition that affects a person's ability to produce sounds that create words) and muscle wasting and atrophy (wasting or thinning of muscle mass). The MDS reflected a BIMS of 0, which indicated she was not able to complete the assessment. Resident #1 required use of a manual wheelchair, and she required set up or clean-up assistance with eating and required substantial/maximal assistance and dependent on staff for all other ADLs. Record review of Resident #1's current, undated, Care Plan reflected the following plans of care:- Resident #1 had an ADL self-care performance deficit related to musculoskeletal impairment, limited mobility, impaired balance. The care plan goals included the resident participating to the best of the resident's ability and maintaining the resident's current level of function. The care plan interventions included monitoring the resident after each meal to ensure the resident's clothes were clean and dry. - Resident #1 required supervision during meals, had fragile skin related to the aging process, and was at risk for bruising easily and skin tears. The care plan goals included the resident's risk for the development of skin tears and bruising being minimized. The care plan interventions included using a clothing protector to protect the resident's skin and notifying the physician and responsible party when there was a change in the resident's status. Keep skin clean and dry. Interview on 08/11/25 at 9:33 AM with Resident #1's Family Member revealed Resident #1's wheelchair was filthy and nasty. The Family Member stated the wheelchair looked like it had never been cleaned, and it should be cleaned. The Family Member stated the facility refused to clean and sanitize the wheelchair. The Family Member stated the arm rests on Resident #1's wheelchair were worn down and could potentially cause bruises on the underside of the resident's forearms. The Family Member further stated, Any normal person would not want to sit in a dirty wheelchair, so why does the facility think its ok for [Resident #1] to sit in a dirty wheelchair. Observation and interview on 08/11/25 at 10:41 AM revealed Resident #1 used her wheelchair for mobility throughout the facility. The arm pad covers on her wheelchair's armrests were torn and exposed the padding. The wheelchair had caked on food, dirt, and debris on both sides. Observation of Resident #1's arms revealed no findings of wounds, skin tears, or bruising. Resident #1 indicated she was mobile throughout the facility a lot, and she did not like her wheelchair to look dirty, Resident #1 did not indicate how having a dirty wheelchair made her feel. Resident #1 did not indicate if she ever asked for the wheelchair to be cleaned or if staff ever attempted to clean it. Interview on 08/11/25 at 11:26 AM with the DOR revealed Resident #1 was seen today (08/11/25) by a contracted vendor to get moldings for a new wheelchair. The DOR stated she noticed the need for a new wheelchair, so she placed a referral on 06/11/25. The DOR stated the reason for the new wheelchair was to assist Resident #1 with balancing and stability while sitting and propelling in the wheelchair. The DOR stated she was aware of how dirty Resident #1's wheelchair was with food and debris; however, she had not reported this to anyone. The DOR indicated she did not have a reason for not reporting the condition of the wheelchair The DOR stated there were times the therapy department would wipe down wheelchairs, but the CNAs on the overnight shift (10:00 PM - 6:00 AM) were responsible for cleaning resident wheelchairs. The DOR stated she noticed the padding on the wheelchair was worn; however, she had not noticed any injury to the resident's forearms. The DOR stated Resident #1 was provided with sleeve protectors, but the resident would remove them. The DOR stated having a dirty wheelchair could place residents at risk of contamination and infections. Interview on 08/11/25 at 11:44 AM with CNA A revealed she had not worked with Resident #1