| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455475 | A. Building<br>B. Wing | 12/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| White Settlement Nursing Center | 7820 Skyline Park Dr<br>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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>(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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 5 residents (Resident #1) reviewed for ADL care. The facility failed to ensure staff consistently performed resident rounds every two hours as required by facility policy and Resident #1's care plan. This failure could place residents at risk for complications associated with delayed care which could negatively affect the resident's safety, comfort, and skin integrity.Record review of Resident #1's admission Record, dated 10/18/25, reflected the resident was a [AGE] year-old male initially admitted [DATE] with diagnoses to include Cerebral Infarction (disruption of blood supply that could result to tissue death), Epilepsy (seizures), Cognitive Communication Deficit (trouble participating in conversations), Dysphagia Oropharyngeal Phase (difficulty swallowing in mouth and throat), Dysarthria and Anarthria (complete loss of speech), Amyotrophic Lateral Sclerosis (loss of muscle control), Muscle Weakness, Unsteadiness on Feet, Lack of Coordination, and Repeated Falls. Record review of Resident #1's Quarterly MDS, dated [DATE], reflected the resident had a BIMS score of 6 out of 15, which indicated severe cognitive impairment. In MDS Assessment Section GG-Functional Abilities revealed resident was dependent or required substantial assistance for ADL care. Record review of Resident #1's care plan, revised date 10/21/24, reflected: Focus: ADLs: [Resident #1] an ADL Self Care Performance Deficit related to: Limited ROM, Limited Mobility, Confusion. Requires 2 staff members to assist [Resident #1] due to size, extensive assistance, and high fall risk. Goal: [Resident #1] will participate to the best of their ability and maintain current level of functioning with activities of daily living (ADLs) through next review date. Interventions: Hoyer lift x2 staff. Resident educated to use call light prior to attempting activities and wait for assistance. Remind/educated resident on physical limitations and inability to walk without assistance. Staff will frequently round to anticipate needs. Resident is Max assist. Bed Mobility: Extensive assistance. Transfers: Total Dependence assistance x2 staff using a Hoyer Lift. Eating: SUPERVISION-LIMITED ASSIST X 1-2 STAFF. Toileting: Total Dependence assistance. Ambulation: n/a. Wheelchair: Extensive assistance. Dressing: Extensive assistance. Person Hygiene: Extensive assistance. Bathing: TOTAL ASSIST X 1-2. Focus: Incontinence: [Resident #1] is incontinent of bowel/bladder related to Alzheimer, confusion, impaired mobility, physical limitations. Goal: [Resident] will be clean and odor free throughout next review date. Interventions: INCONTINENT: Check frequently for wetness and soiling, every two hours, and change as needed. In an interview on 10/18/25 at 2:24 PM, Resident #1 stated staff did not round every 2 hours. Resident #1 also stated staff did not ensure his call light was always within his reach. Resident #1 revealed there were times that staff did not respond when he pressed his call light. Resident #1 also revealed at times, staff had come into his room, turned off his call light, and left without addressing his needs. Resident #1 stated numerous times staff on the 2:00PM-10:00PM shift had ignored aiding. Resident #1 stated his roommate had to use his call light to assist him. He stated he witnessed evening staff sitting in the halls talking on the phone instead of assisting with his needs. In an interview on 10/18/25 at 2:28 PM, Resident #1's roommate revealed he did not need much assistance but Resident #1 did. He revealed staff did not round Resident #1 every two hours. He also stated at times the CNAs did rounds and did not return to their room. He stated staff did not always ensure Resident #1 call light was within his reach. Resident #1's roommate also revealed staff did not always answer his roommate's call light. He stated he used his call light to get Resident #1 assistance. Resident #1's roommate revealed staff would leave Resident #1 in his brief for hours after the call light had been pressed. He also stated when staff took long to answer the call light, he would go into the hall to get staff. Observation on 10/18/2025 at 2:48 PM, two CNAs seated in the hall on their cell phones. At the time, Resident #1 stated he needed assistance due to dry throat but was unable to reach his call light from the floor. In an interview on 10/18/25 at 2:50 PM, CNA A stated she had finished her first rounds for rooms 21, 22, 23, 24. 25, and 26. CNA A also stated she was sitting while she waited for ice to be passed to residents on the opposite end of the hall. CNA A stated Resident #1's room was worked by CNA B, so CNA B would assist. She stated there was only one ice chest for the entire hall. She also stated while she waited, she was on her phone taking care of her kids. In an interview 10/18/25 at 3:01 PM, the DON stated expectations once staff arrived for shift was to complete their rounds. She stated when staff came in for their shift, she expected them to check on residents, check to ensure call lights were within reach, provide showers, and get residents' water. She |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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 the facility was adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or a centralized staff work area for 1 of 5 resident rooms (Resident #1) reviewed for call lights. The facility failed to ensure a call light in Resident #1 room was accessible. Resident #1's call light was observed on the floor out of his reach while he was in bed on 10/18/25. This failure could place residents who rely on the call light system to have delayed response or no way to contact staff to meet their needs. Findings included: Record review of Resident #1's admission Record, dated 10/18/25, reflected the resident was a [AGE] year-old male initially admitted [DATE] with diagnoses to include Cerebral Infarction (disruption of blood supply that could result to tissue death), Epilepsy (seizures), Cognitive Communication Deficit (trouble participating in conversations), Dysphagia Oropharyngeal Phase (difficulty swallowing in mouth and throat), Dysarthria and Anarthria (complete loss of speech), Amyotrophic Lateral Sclerosis (loss of muscle control), Muscle Weakness, Unsteadiness on Feet, Lack of Coordination, and Repeated Falls. Record review of Resident #1's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 6 out of 15, which indicated severe cognitive impairment. In MDS Assessment Section GG-Functional Abilities revealed resident was dependent or required substantial assistance for ADL care. Record review of Resident #1's care plan, revised date 10/21/24, revealed Focus: Visual Function (Impaired): [Resident #1] has impaired visual function and is at risk for falls, injury. Goal: [Resident #1] will maintain optimal quality of life and not experience a decline in ADL functional abilities, or an injury related to vision loss in the next 90 days. Interventions: Anticipate needs and meet them as able. Keep call light in reach when in room or bathroom. Focus: Communication (Impaired): [Resident #1] has a communication problem related to Alz and he may miss part of simple directions given. History of CVA, causing speech to be slurred/muffled at times. Goal: [Resident #1] will have needs met in a timely manner, dignity will be maintained, and current level of functioning will be maintained over the next 90 days. Interventions: Ensure/provide a safe environment: Call light in reach, Adequate low glare light, Bed in lowest position and wheels locked, Avoid isolation. Focus: ADL's: [Resident #1] an ADL Self Care Performance Deficit related to: Limited ROM, Limited Mobility, Confusion. Requires 2 staff members to assist [Resident #1] due to size, extensive assistance, and high fall risk. Goal: [Resident #1 will participate to the best of their ability and maintain current level of functioning with activities of daily living (ADLs) through the next review date. Interventions: Resident educated to use call light prior to attempting activities and wait for assistance. Remind/educated on physical limitations and inability to walk without assistance. Staff will frequently round to anticipate needs. Resident is Max assist. Focus: Falls: [Resident #1] the potential for further falls related to cognitive impairment, incontinence, Gait/balance problems. [Resident #1] has an actual hx of falls related to confusion with no injuries and unable to balance my own body weight for positioning. Goal: [Resident #1] will be free of falls through the next review date. Interventions: anticipate and meet need of resident. Place frequently used items within reach. CALL LIGHT WITH IN REACH, CALL [DON'T] FALL SIGNAGE. Observation on 10/18/25 at 2:23 PM, Resident #1 was lying in bed watching television. Resident #1's call light was observed on the floor approximately 2 feet away. In an interview on 10/18/25 at 2:24 PM, Resident #1 stated staff did not round every 2 hours. Resident #1 also stated staff did not ensure his call light was always within his reach. Resident #1 revealed there were times that staff did not respond when he pressed his call light. Resident #1 also revealed at times, staff had come into his room, turned off his call light, and left without addressing his needs. Resident #1 stated numerous times staff on the 2:00PM-10:00PM shift had ignored aiding. Resident #1 stated his roommate had to use his call light to request assistance for him. 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