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	05/08/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain good grooming, and personal hygiene for 1 of 3 residents (Resident #96) reviewed for ADL care. The facility failed to ensure Resident #96's fingernails were cut. This failure could place residents at risk for poor hygiene, dignity issues, and decreased quality of life. Findings included: Record review of Resident #96's Admission Record, dated 05/07/25, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. Record review of Resident #96's MDS assessment, dated 03/31/25, reflected the resident had diagnoses which included hyperlipidemia (abnormally high levels of lipids in the blood), seizure disorder (chronic brain condition characterized by recurrent seizures caused by abnormal electrical activity in the brain), and cataracts (clouding of the lens of the eye), glaucoma (eye condition that damages the optic nerve), and macular degeneration (affects the central part of the retina). The MDS also reflected the resident had severe cognitive impairment with a BIMS score of 2, and he required partial/moderate assistance from staff with personal hygiene. Record review of Resident #96's Care Plan, revised on 03/26/25, reflected: Focus: ADLs: [Resident #96] has an ADL Self Care Performance Deficit and is at risk for not having their needs met in a timely manner . Interventions: Provide shower, shave, oral care, hair care, and nail care per schedule and when needed. Observation and interview on 05/06/25 at 10:00 AM of Resident #96 revealed he was sitting in a wheelchair in his room next to his bed. Resident #96's nails on both of his hands were about a half-inch long. Resident #96 said he was blind, so he could not see his nails, but he could feel that they were very long. Resident #96 said he wanted his nails cut and did not like them to be long. Observation and interview on 05/07/25 at 12:19 PM of Resident #96 revealed he was sitting in a wheelchair in the dining room. Resident #96's nails on both of his hands were about a half-inch long (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/07/25 at 1:21 PM with LVN D revealed she was filling in for the day and only worked with Resident #96 about once a week. LVN D said the CNAs gave residents showers and checked their nails to see if they needed to be cut. LVN D said the CNA would not cut a resident's nails if they were diabetic. She stated the nurse on duty would be responsible for that. LVN D said as far as she knew, Resident #96 was not a diabetic resident. Observation and interview on 05/07/25 at 1:23 PM with LVN D revealed Resident #96 was in a wheelchair in the dining room. LVN D asked Resident #96 if he wanted his nails cut and Resident #96 said, Yes, chop them off. They're too long. LVN D assured Resident #96 they would have his nails cut for him today, and she was not sure why they were not cut before today (05/07/25). Interview on 05/07/25 at 1:45 PM with CNA C revealed she was just assigned to Resident #96 on Monday (05/05/25) of this week. CNA C said she gave Resident #96 a shower on both Monday (05/05/25) and today (05/07/25). CNA C said she was not sure if Resident #96 was a diabetic resident or not. CNA C said she knew not to cut a diabetic resident's nails because the nurse was supposed to do that. CNA C said she should have checked with the nurse to see if Resident #96 was a diabetic resident or not. CNA C said normally she checked a resident's nails on shower days to see if they needed to be cut or not but she did not check Resident #96's nails this week. CNA C said she saw Resident #96's nails and said they were very long. Interview on 05/08/25 at 9:59 AM with the DON revealed residents' nails were clipped during showers unless they were diabetic because then the nurse would be responsible for doing that task. The DON said the nurse on duty should be looking at a resident's nails and also the Wound Care Nurse during the weekly skin assessments that she completed. The DON said she expected CNAs to offer nail care at least once per week. The DON said if a resident's nails were long they were at risk of scratching themselves. The DON said CNAs were trained to provide nail care during showers. Record review of the facility's Nail Care policy, dated 04/25/14, reflected: .Procedure: 1. Assemble equipment 2. Knock on door and request entrance 3. Introduce self, explain procedure and provide privacy 4. Wash hands 5. Fill basin with warm water and alternate soaking hands 6. Carefully brush nails with nailbrush to remove dirt or clean with orange stick 7. Dry hands 8. Gently push cuticles back with orange stick . 9. Trim nails and file for smoothness, as needed .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observations, interviews, and record review, the facility failed to ensure that residents who received nutrition by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 of 3 residents (Resident #45) reviewed for enteral feeding. The facility failed to follow physician order for Resident #45 pertaining to his enteral feeding downtime. This failure placed residents at risk of dehydration, aspiration pneumonia, and metabolic abnormalities. Findings included: Record review of Resident #45's Admission Record dated 05/08/25 reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #45's quarterly MDS assessment dated [DATE] reflected his diagnoses included nontraumatic intracerebral hemorrhage in the brain stem (stroke), chronic respiratory failure with hypoxia (low levels of oxygen in your body tissues), unspecified cirrhosis of liver (chronic liver disease), and gastrostomy status (tube inserted through the belly that brings nutrition directly to the stomach). Resident #45's BIMS score was not complete due to Resident is rarely/never understood. The MDS further revealed Section K - Swallowing/Nutritional Status indicated the resident's nutritional approach was a feeding tube. Record review of Resident #45's care plan revised date 04/22/25 reflected: Focus: Feeding Tube: Resident requires the use of a feeding tube and is at risk for aspirations, weight loss, and dehydration. Goal: Resident will be adequately nourished and remain within 5% of their ideal body weight for the next 90 days. Resident will maintain adequate nutritional and hydration status as evidenced by weight being stable, no signs or symptoms of malnutrition, or dehydration through review date. Interventions: Administer tube feeding and water flushes as ordered. WEEKLY & Monthly weights AS INDICATED PER POLICY. Report any significant weight loss/gain to the physician. Focus: Nutritional Status: [Resident #45] is NPO and at nutritional & hydration risk related to enteral feeding OSMOLITE 1.5 CAL 65CC /HR X22HR, H2O @ 100CC/4HR X 22HR. Goal: Resident will maintain adequate nutritional and hydration status as evidenced by weight being stable with no signs or symptoms of malnutrition or dehydration being present through the next review date. Interventions: Weight and record at least monthly. Report signs and symptoms of malnutrition such as emaciation (abnormally thin or weak), cachexia (condition that causes significant weight loss and muscle loss), temporal wasting (causes significant weight loss and muscle loss) or any significant weight loss to the physician as detected. A significant weight loss is more than 5% in 30 days, more than 7.5% in 90 days, or more than 10% in 180 days. Record review of Resident #45's May 2025 MAR, reflected an order for Enteral Feed Order every shift continuous feeding Osmolite 1.5 CAL @ 65 ML/HR X 22 HR via PEG Tube AND 100CC/4HR H2O. Start Date 03/31/25. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #45's May 2025 MAR, reflected an order for Enteral Feed Order one time a day Resume feeding at 0400 [4:00 AM] via PEG Tube. Start date 03/26/25. MAR indicated feeding start time 0200 [2:00 AM]. Record review of Resident #45's May 2025 MAR reflected an order for Enteral Feed Order one time a day Turn off feeding pump at 0000 am [12:00 AM]. Start dated 04/04/25. MAR indicated feeding down time 0000 [12:00 AM]. Record review of Resident #45's weights revealed the following: 5/1/2025 07:02 AM 244.8 Lbs Mechanical Lift 4/1/2025 12:41PM 246.6 Lbs Mechanical Lift 3/21/2025 18:24 [6:24 PM] 247.6 Lbs Mechanical Lift 3/6/2025 08:22 AM 249.8 Lbs Mechanical Lift Observation on 05/06/25 at 10:22 AM revealed Resident #45 lying in bed. He could not answer questions. Resident #45's feeding pump was turned off. The formula bag was dated 05/06/25 at 4:00AM at a rate of 65 mL/hr. The water bag was dated 05/06/25. Observation on 05/06/25 at 12:04 PM revealed Resident #45 being connected to his g-tube by LVN H. LVN H stated resident down time was from 10AM to noon. Observation on 05/07/25 from 8:38 AM to 10:11 AM revealed Resident #45 lying in bed. He could not answer questions. Resident #45 was connected to his feeding pump and the feeding pump was running. Observation on 05/07/25 at 10:20 AM revealed Resident #45 lying in bed. Resident #45's feeding pump was turned off. Observation on 05/07/25 at 12:33 PM revealed Resident #45 lying in bed. Resident #45 was connected to his feeding pump and the feeding pump was running. Interview on 05/07/25 at 1:21 PM with LVN H revealed she was the nurse assigned to Resident #45. She stated resident was fed by a g-tube and received 22 hours of feeding time. LVN H stated Resident #45 had a downtime of 2 hours. She stated she stopped Resident #45's feedings at around 10 AM and reconnects at around noon. LVN H reviewed Resident #45's MAR and stated she had no orders for downtime during her shift. LVN H reviewed Resident #45's physician orders and stated she was not aware resident had an order for downtime from 0000AM (12AM) and reconnect at 2AM. She stated prior to Resident #45 going to the hospital in March 2025 resident downtime was at 10AM. She stated she did not review physician orders upon admission from the hospital in March. LVN H stated she had been providing Resident #45 with an additional 2-hour downtime since his admission in March 2025. She stated the potential risk of not following physician orders and providing 2 additional hours of downtime could cause weight loss. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 05/07/25 at 3:20 PM a witnessed weight check was completed on Resident #45 via mechanical lift. Resident #45 had a weight of 227.0 pounds. Resident #45 had a weight loss of a -7.27 % in 6 days. CNA O stated the facility had all scales calibrated on 05/01/25 after resident was weighed. Interview on 05/07/25 at 4:34 PM with LVN N revealed she worked the 10 PM to 6 AM shift and had been the nurse assigned to Resident #45. LVN N stated Resident #45 had a g-tube feeding downtime from midnight to 2 AM. LVN N stated Resident #45 was supposed to be connected to his feeding pump for 22 hours. LVN N stated she was not sure of any other downtime. Observation on 05/07/25 at 5:02PM revealed two additional weight checks completed on Resident #45 via mechanical lift and wheelchair revealed a weight of 227.6 pounds. Interview by phone on 05/07/25 at 5:20 PM, with the Dietitian revealed she could not recall much of any weight loss on Resident #45. She stated g-tube feedings usually run for 20 to 22 hours depending on the resident. She stated an additional 2 hours of downtime should not cause a weight loss of 17 pounds in a week. She stated she was unaware of Resident #45's 17-pound weight loss, and she stated it would be considered significant weight loss; however, the concern would be the weight discrepancy. She stated something might have been wrong with the scale. The Dietitian stated the resident BMI would depend on resident body weight and height. She stated they do not follow Resident #45 closely unless BMI was under 18 or over 40. Resident #45 BIM was ay 35.5. The Dietitian stated providing Resident #45 4-hours of downtime did not contribute to his weight loss. She stated it had to be the scale. The Dietitian stated she was unable to provide any potential risk for not following physician orders without calculating Resident #45's feeding rate. Record review of email received from Dietitian dated 05/08/25 at 8:48 AM revealed, Below are the calculations you were asking for yesterday! Kcal Needs for [Resident #45] based on his height and weight: 2272kcal [Resident #45] is receiving from enteral feeding at 22hr per day: 2146kcal Kcal he would be receiving on 20hr per day: 1950kcal So only 196kcal difference for the day which would not warrant significant weight loss. Interview on 05/08/25 at 9:10 AM with the Rehabilitation Director revealed Resident #45 received OT, PT and ST for 30 minutes each discipline 5 days a week. She stated they provide therapy for Resident #45 during his 2-hour g-tube feeding downtime from 10AM to noon. She stated Therapy brings Resident #45 to the therapy room to complete his therapy. She stated since returning from the hospital on 3/24/25 Resident #45 had been receiving all disciplines from 10AM- noon. The Rehab Director stated Resident #45 had been refusing therapy the last two days (05/06/25-05/07/25). (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/08/25 at 9:15 AM with ADON L revealed she was the ADON assigned to Resident #45. She stated Resident #45 had a g-tube feeding downtime from midnight to 2 AM. She stated Resident #45 had an order for his g-tube feeding downtime from 10AM - noon but it changed when Resident #45 returned from the hospital in March 2025. ADON L stated she was not aware Resident #45 was getting an additional 2-hour downtime until yesterday (05/07/25). ADON L stated if the weight loss was over 5% in number of days it would be considered severe weight loss. She stated prior to yesterday (05/07/25) there were no concerns regarding Resident #45's weight. ADON L stated the additional 2-hour downtime could contribute to Resident #45's weight loss; however, she was unsure if it did. She stated they monitor residents' weights by reviewing them every Friday and if weight loss is noted they would put interventions in place. She stated her expectations were for all nursing staff to follow physician orders and to review them when a resident readmits from the hospital. She stated the risk of not following physician orders regarding downtime could cause dehydration, weight loss or malnutrition. Interview on 05/08/25 at 10:16 AM with the DON revealed her expectations were for her nurses to follow physician orders. She stated Resident #45's downtime was only provided for therapy. She stated she was not aware LVN H was unaware of Resident #45's physician orders for g-tube feeding downtime. She stated she did not believe the additional 2-hour downtime contributed to Resident #45's weight loss. She stated Resident #45 was also on hydrochlorothiazide medication and can also contribute to some weight loss but not cause a big significant weight loss. She stated it might be a scale issue. She stated the facility scales were all calibrated 05/01/25. The DON stated her expectations were for her nurses to check physician orders when a resident readmits from the hospital. She stated during morning meeting physician orders were reviewed. She stated it was the responsibility of the ADONs and herself to ensure physician orders were being followed. Interview on 05/08/25 at 2:17 PM, with the Doctor revealed the goal for a resident on a g-tube would be no weight loss. He stated the resident weight should stay consistent, maybe a variation of 1-2 pounds off but not a significant or severe weight loss. The Doctor stated he could not believe Resident #45 had lost 17 pounds in less than a week, and he stated it had to be a scale error. He stated Resident #45 had been more active with participating in therapy that can contribute with a few pounds weight loss. He stated he expects staff to follow physician orders. He stated an additional 2-hour downtime would not cause a significant weight loss. Follow up interview on 05/08/25 at 3:39PM, with the Doctor revealed Resident #45 receiving an additional extra 2-hour downtime, being on a diuretic medication and loss of fluid did not contribute to Resident #45's weight loss. He stated it could but not a large amount of weight loss. The Doctor stated no person would be able to lose 17 pounds in a week. He stated there might be something wrong with how the staff are obtaining the resident weight. He stated he observed Resident #45 a week ago and there was nothing clinically wrong with him. Review of the facility Feeding Tube Administration, Nutrition and Care policy, dated 04/01/25, reflected: Enteral feedings will be administered per physician order. Complications related to enteral feedings will be minimized through provision of proper care. Residents receiving enteral feedings will receive adequate nutrition and fluid to meet their individual needs, to the extent possible in consideration of their clinical condition and wishes.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on observation, interview, and record review, the facility failed to ensure residents who needed respiratory care were provided such care, consistent with professional standards of practice, for 1 of 1 (Resident #46) residents reviewed for tracheostomy care. The facility failed to ensure Residents #46 had an emergency tracheostomy kit at the resident's bedside. This failure placed the resident at risk of delayed lifesaving interventions. Findings included: Record review of Resident #46's quarterly MDS assessment, dated 03/14/25, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included seizure disorder (uncontrolled jerking, loss of consciousness, blank stares, or other symptoms caused by abnormal electrical activity in the brain), respiratory failure, tracheostomy status (condition of having a tracheostomy, which is a surgically created opening in the trachea to facilitate breathing), and diabetes (chronic metabolic disease characterized by elevated level of blood glucose or blood sugar level). Record review also did not reflect a BIMS score as the resident was rarely/never understood. Review of Resident #46's quarterly MDS assessment also indicated she was totally dependent upon staff for her ADLs. Record review of Resident #46's care plan, dated 05/08/25, revealed her tracheostomy status is related to acute and chronic respiratory failure with hypoxia (a condition where the body or a specific region of the body is deprived of an adequate oxygen supply at the tissue level) with potential complications such as respiratory distress. The care plan reflected intervention, Keep extra trach (Shiley (a specific type of tracheostomy tube designed to provide an airway for individuals who have had a tracheostomy) 6 cm) at bedside. If tube is coughed out and tube cannot be reinserted obtain medical help immediately. Monitor/document for signs of respiratory distress, elevate HOB (Head of bed) and stay with resident. Observation on 05/08/25 at 8:38 AM of Resident #46's tracheostomy care with RN F revealed no emergency trach kit at bedside. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/08/25 at 9:15 AM with RN F revealed there was no emergency trach kit (containing a bag valve mask) at Resident #46's bedside and the next lower size trach was not easily accessible. RN F stated that the bag valve mask should be easily accessible in the resident's room as well as the next lower size trach for emergency purposes. RN F stated she could not find the next size lower trach easily in the room due to the tracheostomy supplies' disorganization in the drawers where the supplies were contained. RN F revealed she could not recall an emergency trach kit in Resident #46's room in the four weeks she has been employed at the facility as Resident #46's nurse. RN F said that it was everyone's responsibility to ensure that the emergency kit was at the resident's bedside. RN F then stated that it was nurses' responsibility to ensure that the next lower size trach was easily accessible. RN F stated that if she could not locate an emergency kit, she should report it to ADON M. RN F also revealed that she should report to ADON M if the trach supplies were not organized. RN F said that she should check every shift to ensure both these items were in the room and easily accessible for emergency purposes. RN F stated that the importance of the bag valve mask was so that in an emergency if the resident's respirations decrease, the resident could receive oxygen. RN F then said that if the lower size trach was not available it could affect the resident's respirations due to sputum secretions (mucus and other matter coughed up from the lung and airways). RN F did not recall the last in-service on this topic. Interview on 05/08/25 at 9:28 AM with ADON M revealed the facility policy stated there should be an emergency trach kit (containing a bag valve mask) and the next lower size trach easily accessible in the rooms of residents with diagnoses of tracheostomy status. ADON M stated that she remembered the emergency trach kit (containing a bag valve mask) in the room on Tuesday, 05/07/25. ADON M said that she thought that it must have gotten knocked off the wall and fell on the floor while moving the resident's bed and then thrown away because they were following proper infection control practices. ADON M stated that she thought someone forgot to place another emergency trach kit (containing a bag valve mask) on the wall. ADON M stated that it was the nurses' and the ADON's responsibility to ensure that the emergency trach kit and the next lower size trach were easily accessible and organized. ADON M said that the nurse should check for these daily when they make their initial rounds. ADON M revealed that if these items were not easily accessible in an emergency, the resident would not be able to breathe. ADON M stated that if these items were not available, the nurse should report it to the ADON. ADON M then revealed that if the ADON could not locate the emergency trach kit and next size lower trach, they should notify the DON so that they could be ordered. Interview on 05/08/25 at 9:52 AM with the DON revealed the facility policy stated there should be an emergency trach kit (containing a bag valve mask) and the next lower size trach easily accessible in rooms of residents with diagnoses of tracheostomy status. The DON stated that she remembered the emergency trach kit (containing a bag valve mask) in the room on Tuesday, 05/07/25. The DON said that she thought that it must have gotten knocked off the wall when life safety (the state representative who measures the systems in place to protect individuals in emergencies, primarily involving fire, but also other hazards such power failures, security threats, earthquakes, floods, etc.) was in the room, fell on the floor, and thrown away while moving the resident's bed. The DON then stated that it was the nurse's, ADON's, and DON's responsibility to ensure the next lower size trach could be easily located. The DON said that the nurse should notify the ADON and DON if they could not locate it. The DON concluded by stating that if the emergency trach kit (containing a bag valve mask) and the next lower size trach are not easily accessible in rooms of residents with tracheostomy status, there could be a delay in care causing respiratory distress. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Respiratory Care Services: Tracheostomy Care, policy, dated 03/03/23, reflected: .Procedure: .2. Gather necessary supplies: . Ambu bag [a handheld medical device used to manually ventilate a person who is not breathing or is breathing inadequatel] should already be bedside .Emergency trach replacement tube same size and one smaller (should ALWAYS be present bedside) .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation, interview, and record review, the facility failed to ensure the medication error rates are not 5 percent or greater. There were 5 errors out of 44 opportunities which resulted in an 11% percent medication error rate for 1 of 6 residents (Resident #87) reviewed for medication administration. RN F cocktailed (mixed together) five of Resident #87's medications instead of administering them separately via his feeding tube, creating an error rate of 11%, (5 errors out of 44 opportunities). This failure could place residents at risk of having their gastric tubes clogged. Findings included: Record review of Resident #87's undated Admission Record reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including stroke, communication deficit, feeding tube placement, and diabetes. Record review of Resident #87's quarterly MDS, dated [DATE], reflected a BIMS score of 11, indicating moderate cognitive impairment. His Functional Status assessment indicated he required assistance from staff for all his ADLs. Record review of Resident #87's care plan reflected he had cognitive impairment related to his stroke; he had swallowing problems related to his stroke, requiring the use of a gastric tube; and he required a gastric tube for all of his nutrition. Record review of Resident #87's physician orders revealed an order dated 11/08/24 for every shift Flush enteral tube with 30 ml water pre/post medication administration and 5-10 ml water between each medication. Observation on 05/07/25 at 7:16 AM revealed RN F crushed Resident #87's pantoprazole 40 mg, Folic acid 1 mg, famotadine 20 mg, aspirin 81 mg, and omeprazole 20 mg together and administered them together instead of individually with a water flush between each medication as ordered. Interview on 05/07/25 at 10:08 AM with Resident #87 revealed his medications are always given like they were this morning. He stated it was always one cup of medications that were flushed with is Osmolyte drink. He stated he did not know the medications were supposed to be administered one at a time. Interview on 05/07/25 at 11:25 AM with RN F revealed she did sometimes cocktail her medications when she was busy in order to save time. She stated she knew she was not supposed to cocktail the medications, but mornings were busy and it was time consuming to administer each medication one at a time and flush between each medication. She could not state a risk of cocktailing medications. (continued on next page)

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/07/25 at 12:55 PM with the DON revealed it was not acceptable to cocktail resident medications when giving them via a gastric tube. The DON stated each medication was to be crushed in its own pouch, diluted with 30 ml of water, administered via the tube and then flushed with 5-10 ml of water before giving the next medication. This was done to reduce the risk of the gastric tube being clogged. The DON stated RN F had not been checked off on gastric tube medication administration yet. Interview on 05/07/25 at 1:37 PM with RN G revealed medications given via a gastric tube had to be crushed and administered individually after being diluted and a water flush between each medication was also required to ensure the tube did not become clogged. Record review of the facility's Enteral Tube Feeding policy, dated 02/10/20, reflected: .7. Each medication is prepared individually so that it can be administered separately. 8. Crushed medications are diluted with at least 5 ml of water when fluid is not restricted. .11. Enteral tube must be flushed with at least 10-15 ml of water between each medication, unless otherwise ordered by the prescriber

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 48236 Based on observation, interview, and record review, the facility failed to ensure the menu was followed for one of one meal (lunch on 05/07/25) reviewed for food and nutrition services. The facility failed to ensure the menu was followed for the lunch meal by: - leaving out the dinner roll for the pureed diets on 05/07/25, and - substituting greens for broccoli florets This failure could place residents at risk of weight loss, altered nutritional status and diminished quality of life. Findings included: Observation on 05/07/25 at 11:30 AM revealed the [NAME] pureed pork roast, greens, and boiled potatoes. No dinner rolls were pureed or served to residents who should have received pureed meals. Observation and Interview on 05/07/25 at 1:10 PM with Dietary Manager J revealed there was no pureed dinner roll on the pureed test tray. Dietary Manager J revealed the [NAME] forgot to prepare the pureed dinner roll. Dietary Manager J revealed the facility policy stated everyone should receive the same meal. Dietary Manager J stated the importance of following the menu was so that residents could receive sufficient calories. Dietary Manager J said that if residents did not receive enough calories, it could lead to possible weight loss and a decline in health. There was no posting observed in the facility of a substitution of the greens for the broccoli florets in the facility on 05/07/25. Dietary Manager J was observed in-servicing her staff on following the menu for special diets on 05/08/25. Observation and interview on 05/07/25 at 1:15 PM with Dietary Manager K revealed she was a dietary manager from a sister facility who was there to oversee the kitchen operations that day. The test tray for the lunch meal was present during this interview, and Dietary Manager K stated she saw there was no pureed dinner roll on the puree test tray. Dietary Manager K said the facility policy was to follow the menu and post substitutions if they occurred. Dietary Manager K revealed the importance of following the menu is so that residents receive all their nutritional value of the day. Dietary Manager K revealed also the cook should notify the facility's manager if there was no pureed bread so that a substitution could be made. Record review of resident council minutes for February, March, and April 2025 reflected there were no complaints for the dietary department regarding substitutions. Record review of the facility's menu, dated 03/14/25, reflected for Wednesday (05/07/25) the following: Lunch - Pork Roast Loin Garlic Herb, Buttered Broccoli Florets, Boiled Potato, Dinner Roll, Chocolate Pudding. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Menu Changes and Substitutions policy, revised 08/02/17, reflected: Policy: Any variation from the planned menu will be properly documented by the Dietary Services Manager (DSM) and reviewed and signed by the Dietician. Menu changes and substitutions, when necessary, will be made with foods of equivalent nutritive value .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 5 residents (Resident #38) reviewed for infection control. CNA A and CNA B failed to wear the appropriate PPE while they transferred Resident #38, who was on Enhanced Barrier Precautions, to her bed. This failure could place residents at risk of being infected by staff in contact with other residents with infections. Findings included: Record review of Resident #38's MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included high blood pressure, neurogenic bladder (a condition where the nerves that control the bladder do not function properly), paraplegia , and traumatic brain injury. The MDS reflected the resident had impairment to both sides of her lower extremities and used a wheelchair for mobility and was dependent with the help of two staff members for transfers. Record review of Resident #38's care plan revised on 03/05/25 reflected she had a urinary catheter related to neuromuscular dysfunction of bladder and was at risk for urinary tract infections. Interventions included she was on enhanced barrier precautions. Observation on 05/06/25 at 12:48 PM revealed Resident #38 was being transferred from her wheelchair to her bed via mechanical lift by CNA A and CNA B. CNA A was wearing gloves, but no gown and CNA B was not wearing any PPE as they assisted the resident into bed and hung the catheter bag on the bed. Observation on 05/06/25 at 12:52 PM of Resident #38's room revealed there was PPE that hung on the door that included gowns and there was a yellow sign outside the door which reflected: .for B bed wear gown and gloves for dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting device care or use: central line urinary catheter, feeding tube, trach, and wound care Interview on 05/06/25 at 12:57 PM with CNA A revealed she was supposed to wear gown and gloves while they transferred Resident #38 into bed, but she had forgotten. CNA A said it was important to wear the appropriate PPE because it kept germs from spreading. Interview on 05/06/25 at 1:00 PM with CNA B revealed she had assisted CNA A transfer Resident #38 from her wheelchair to her bed and she did not realize the resident was on enhanced barrier precautions therefore did not wear any PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/08/25 at 10:40 AM with the DON revealed residents that were on enhanced barrier precautions were identified with the PPE on the door and the signs outside the rooms. The DON said CNA A and CNA B both should have worn gloves and gowns to transfer Resident #38 back into bed because the resident was on enhanced barrier precautions. The DON further stated it was important for the staff to wear the appropriate PPE because it prevented the spread of communicable diseases. Record review of the facility's Infection Prevention and Control Program policy, revised 03/26/25, reflected the following: .6. Enhanced Barrier Precautions EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO 's to staff hands and clothing. EBP are indicated for residents with any of the following: .b. Wounds and/or indwelling medical devices (e.g., central lines, urinary catheter, feeding tube, tracheostomy/ventilator) .During high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide bedrooms that don't allow residents to see each other when privacy is needed. 43791 Based on observations, and interviews, and record review, the facility failed to ensure resident rooms were equipped to assure full visual privacy for each resident for 5 of 20 residents (Residents #20, #24, #65, #78, and #200) reviewed for privacy. The facility failed to ensure full visual privacy for Residents #20, #24, #65, #78, and #200. This failure could cause residents embarrassment, of loss of dignity. Findings included: Observation and interview on 05/06/25 at 10:25 AM revealed Resident #65's privacy curtain did not extend across the foot of his bed, leaving a gap on one side or the other. Hangers for a second curtain were present in the track, but the second curtain was not present. Resident #65 stated he did not like the gap in the curtains, and he wanted full privacy. Observation and interview on 05/06/25 at 10:33 AM revealed Resident #24 had no privacy curtain at the foot of her bed. There was a track in place but no hangers or curtain present. Resident #24 stated there had been no curtain for several months, since her last roommate left. She did not like not having privacy. Observation and interview on 05/06/25 at 10:41 AM revealed Resident #20's privacy curtain for the end of his bed was tied up in a knot, and he was missing 17 slats out of his window blinds leaving him with no privacy from the smoking area outside his window. Resident #20 stated the curtain did not bother him as much as the blinds did. He stated the blinds had been that way for as long as he could remember. He stated he would like more privacy when changing clothes. Observation and interview on 05/06/25 at 10:45 AM revealed Resident #200's privacy curtain was in place but would not extend around his bed due to the hangers not sliding in the track. Resident #200 stated it had been that way since he was admitted last month. He stated he liked to have privacy when changing clothes. Observation and interview on 05/06/25 at 11:02 AM revealed Resident #78 had no privacy curtain for the foot of his bed. There was a track in place but no hangers or curtain. Resident #78 stated he would not mind a curtain there but it did not bother him too much since he was in the far bed. Interview on 05/06/25 at 2:45 PM with the Housekeeping Supervisor revealed maintenance was responsible for hanging curtains and repairing the tracks, and housekeeping washed the curtains when needed. She stated maintenance should notify the housekeepers if they needed more curtains to provide full coverage. Interview on 05/08/25 at 9:40 AM with LVN H revealed residents needed their privacy for dignity reasons. The curtain provided them with a sense of having their own space. (continued on next page)

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/08/25 at 9:43 AM with CNA I revealed she had not noticed Resident #20's blinds missing the slats. She stated it was important to replace them because the smoking area was just outside his room and he had no privacy. Interview on 05/08/25 at 9:52 AM with the ADON revealed the residents needed their privacy curtains for their dignity. She stated she would have to speak with staff about reporting missing curtains or broken window blinds. Interview on 05/08/25 at 11:34 AM with the DON revealed privacy curtains and window blinds are in place to provide privacy and dignity for the residents. The curtains should provide full coverage and privacy for the resident, and no gaps were allowed., She stated the curtains should be checked by the CNAs and reported to the nurse or maintenance when they did not work of or provide full coverage. Any dirty or damaged curtains were replaced by housekeeping. Interview on 05/08/25 at 12:08 PM with the Maintenance Director revealed he would hang any curtains that the housekeepers needed hung or make repairs to the tracks if they were reported as not working. He stated he does not check curtains for coverage or functionality unless one was reported to him to be checked. Record review of the facility's Homelike Environment policy, dated 04/24/25, reflected: .2. Privacy and Dignity: Ensure that residents have privacy and that their dignity is maintained at all times. This includes respecting their personal space and providing private areas for personal care and family visits

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to keep the facility free of pests for 1 of 2 halls (station 2) and 1 of 1 activity room and 1 of 4 community bathrooms (community bathroom [ROOM NUMBER]), and 1 of 12 (room [ROOM NUMBER]) resident rooms. The facility failed to ensure an effective pest control program was in place to keep cockroaches out of the facility. This failure could place residents at risk for the potential spread of infection, cross-contamination, and decreased quality of life. Findings included: Observation on 05/06/25 at 10:44 AM of room [ROOM NUMBER], revealed there was a single roach seen running from the resident's closet to the resident's dresser. Observation on 05/07/25 at 1:52 PM revealed there were 6 live roaches, of various sizes, in the community bathroom [ROOM NUMBER], next to the activity room. Observation on 05/08/25 at 8:36 AM revealed there was a live roach seen running by the water dispenser in the activity room. Observation on 05/08/25 at 2:25 PM revealed there were 7 live roaches in the bathroom next to the activity room (community bathroom [ROOM NUMBER]) and two of the roaches ran under the door into the hallway. Review of the pest control log for the past three months reflected the following: 03/04/25 - there were entries in the logbook to treat for American roaches 04/01/25 - evidence found of roach activity in two rooms that were joined by a bathroom 05/06/25 - entries in the logbook to treat staff restroom and nurses station for American roaches Interview on 05/08/25 at 4:16 PM with Resident #9 and #44 revealed they would see lives roaches from time to time but the facility was good about treating their room. Interview on 05/07/25 at 3:46 PM with CNA E revealed there were always live roaches in the bathroom next to the activity room no matter how many times pest control treated. CNA E said pest control would treat the facility and that bathroom but it did not seem to help. CNA E further stated she had not seen live roaches in the resident rooms. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/08/25 at 10:51 AM with the Administrator revealed they have had issues with roaches and pest control was making weekly visits. They have had a lot of difficulty controlling them and some would have to do with the residents storing food and housekeeping not keeping with the cleanliness. Interview on 05/08/25 at 12:00 PM with the Maintenance Director revealed he had seen roaches in the facility and when he is made aware, they will have the room cleaned and treated by pest control. He was aware there were roaches in Resident #9 and #44's room and the Maintenance Director said that was one of the rooms where the resident stored snacks and food from the kitchen. Review of the facility's policy titled Pest Control Program implemented on 01/2020 reflected the following: It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents.