

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure based on the comprehensive assessment of a resident, that a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 1 residents (Resident #6) reviewed for treatment of pressure ulcers.1. The facility failed to implement interventions for Resident #6's right arm contracture which led to the development of a stage 3 pressure ulcer (wound developed from pressure that extends through the skin into the fatty layer but not into the muscle, tendon or bone) to the right palm identified on 06/03/2026.2. The facility failed to ensure Resident #6's dressing to the left hip was dated and initialed.The failures could place residents at risk of developing new or worsening pressure ulcers. Findings include:Findings include:Record review of Resident #6's Significant Change MDS, dated [DATE], reflected he was a [AGE] year-old male with an original admission date of 05/22/24 and readmission date of 04/29/26. Resident #6's diagnoses included stroke, Hemiplegia (partial paralysis of one side of the body) or Hemiparesis (weakness on one side of the body) and Encephalopathy (any disease, damage, or malfunction of the brain that causes altered mental function). Resident #6's BIMS score was blank, and cognitive skills were severely impaired. Resident #6 had upper and lower extremity impairment on both sides and was dependent for all ADLs. Record review of Resident #6's care plan, revealed the following:-Resident #6 had an ADL self-care performance deficit and was dependent on staff for all ADLs, Date initiated 05/23/24.-Resident #6 has the potential for the development of a pressure ulcer, Date initiated 07/20/25 with interventions that included pressure relieving/reducing devices on bed/chair.reposition frequently.-Resident #6 at risk for impaired skin integrity r/t contractures in all extremities, Date initiated 09/12/25 with interventions that included use circular limb off loader to keep hand from resting against other body parts. utilized pillows or foam wedges to avoid direct contract with bony prominences.utilize pressure relieving devices on appropriate surfaces.-Resident #6 had alteration in musculoskeletal status r/t contractures of all moveable joints, Date Initiated 12/01/25 with interventions that included Range of Motion weekly by therapy dated 02/18/26, and wash cloth right thumb and index finger Wash cloth against shoulder and hand on right; Change wash clothes daily dated 02/18/26. Record review of Resident #6's order summary reflected the following:- Cleanse stage 3 right palm wound with wound cleanser. Dry with gauze. Apply gentell blue. Coverwith bordered gauze Wednesday and Saturday and PRN if soiled or malfunction start date 07/03/26- Cleanse Pressure unstageable DTI left lateral (away from the middle of the body) hip with wound cleanser. Dry with gauze. Cover with honey hydrogel. Cover with gauze island dressing MWF and PRN start date 07/29/26.- Skilled Occupational Therapy services for PASSR services 1xs for 90 days for self-care, ADL retraining,therapeutic activities, therapeutic exercises, neuromuscular re-education, and manual therapy, and safety education order (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
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Actual harm Residents Affected - Few	date 6/09/26- Skilled Physical therapy for 1X/WK FOR 90 days for PASRR services order date 06/09/26Record review of Resident #6's skin note dated 06/03/26, written by LVN I reflected in part: 0Skin Issue: #003: New skin Issue. Location: Right palm. Laterality / Orientation: Lateral. Issue type: Other skin issue. Other skin issue description: unstageable DTI Progress: New: new wound. Wound acquired in-house. Exact date: 06/03/2026 Signs and symptoms of infection: None. Painful: No. Staged by: In-house nursing. Length (cm): 2 Width (cm): 2.2 Depth (cm): 0.1 Undermining: No. Tunneling: No. Granulation (new temporary connective tissue that fills a wound): 80%. Slough (dead tissue usually yellow, white or tan): 20%. Exudate (wound drainage or fluid) amount: Moderate. Exudate type: None. Odor after cleansing: None. Periwound (tissue surrounding the wound): Attached. Surrounding tissue: Intact. Induration: None present. Edema (swelling): No swelling or edema. Periwound temperature: Normal. Dressing saturation: None 0%. Cleansing solution: Generic wound cleanser. Debridement: Autolytic (using the body's own enzymes and moisture to break down dead tissue). Primary dressing: Calcium alginate. Secondary dressing: Composite dressing. Modalities: None. frequency of treatment: q day.Record review of Resident #6's wound physician's notes, dated 06/10/26, reflected Stage 3 pressure wound of the right hand full thickness.Duration >7 days Wound Size (L x W x D): 1.3 x 1.8 x 0.1 cmSurface Area: 2.34 cm²Exudate: Moderate SerousGranulation tissue: 100 %Pain Assessment: NoneInfection Assessment: No sign(s) of infection. ADDITIONAL WOUND DETAILSevere contracture limiting ability to debride this woundDRESSING TREATMENT PLANPrimary Dressing(s)Methylene blue foam apply twice a week and as needed: if saturated, soiled, or dislodged. For 30 daysSecondary Dressing(s)Gauze island with border apply once weekly and as needed: if saturated, soiled, or dislodged. For 30 days.Record review of Resident #6's wound physician's notes, dated 06/17/26, reflected Stage 3 pressure wound of the right hand full thickness. Wound Size (L x W x D): 1.3 x 1.5 x 0.1 cmSurface Area: 1.95 cm²Exudate: Moderate SerousGranulation tissue: 100 %Wound progress: Improved evidenced by decreased surface areaPain Assessment: NoneInfection Assessment: No sign(s) of infection.Record review of Resident #6's wound physician's notes, dated 07/15/26, reflected Stage 3 pressure wound of the right hand full thickness. Wound Size (L x W x D): 1.4 x 1.3 x 0.1 cmSurface Area: 1.82 cm²Exudate: Moderate SerousGranulation tissue: 100 %Hypergranulation (excessive granulation tissue that extends above the surround skin) tissue present within the wound margins.Wound progress: Not at goal due to contracturesPain Assessment: NoneInfection Assessment: No sign(s) of infection.Record review of Resident #6's wound physician's notes, dated 07/22/26, reflected Stage 3 pressure wound of the right hand full thickness. Wound Size (L x W x D): 0.8 x 0.7 x Not Measurable cmDepth is unmeasurable due to presence of tissue overgrowth.Surface Area: 0.56 cm²Exudate: Moderate SerousGranulation tissue: 100 %Wound progress: Improved evidenced by decreased surface areaPain Assessment: NoneInfection Assessment: No sign(s) of infection.Observation on 07/28/2026 at 3:00 PM, revealed Resident #6 was lying in bed. The resident was not able to answer questions. Resident #6's left hand appeared contracted. No offloading device was observed on Resident #6 wrist or hand.Observation on 07/29/26 at 9:24 AM, revealed Resident #6 was lying in bed, bordered gauze was on the right palm, no wash clothes or offloading device was observed in or around the hands or wrists. CNA K was in the room to check if Resident #6 needed to be changed. Interview on 07/29/26 at 9:55 AM, LVN I stated Resident #6 was severely contracted. She stated he had wedges and repositioning devices and a device that was round that fit around the arms to help lift it. She stated the CNAs were responsible for putting them on and Resident #6 was supposed to wear them all the time. Observation on 07/29/26 at 10:07 AM, revealed Resident #6 was lying in bed, no wash clothes or offloading device was observed in or around the hands or wrists. A blue round offloading device (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Actual harm Residents Affected - Few	was observed in the wheelchair. Interview on 07/29/26 at 10:08 AM, CNA L stated he usually worked nights and stated Resident #6 was contracted and had not seen the blue offloading device before. He stated when he cleaned Resident #6's hands sometimes he would fold a towel and place it in his hands and he would grip it. He stated therapy and the Wound Care Nurse checked on him. He stated he placed pillows under his legs to relieve pressure and if he noticed any issues he would report to the nurse. Interview on 07/29/26 at 10:15 AM, LVN F stated Resident #6 did not have an order for an offloading device but he saw therapy go in and apply it to Resident #6's wrists. He stated he did not get instructions Resident #6 was supposed to wear it all the times. He stated nurses and CNAs were responsible for turning and repositioning Resident # 6 every two hours and they would put a pillow in between his chest and arms to relieve pressure. He stated the Wound Care Nurse provided treatment to the wound on the right palm. He stated no CNAs had reported any changes to skin to him. Interview on 07/29/26 at 11:06 AM, the DOR stated Resident #6 was currently receiving PT, OT and ST through PASARR one time a week for each. She stated Resident #6 did not stretch enough to use a splint and they tried to stretch out the contractures, but Resident #6 could not tolerate a splint. Observation and interview on 07/29/2026 at 11:33 AM, LVN F stated the nurse was responsible for cutting Resident #6's nails and said he cut them a couple of weeks ago. He stated CNAs were to clean Resident #6's hands and if they were not cleaned, he could develop skin issues or wounds. LVN F put on gloves and turned Resident #6's right hand which revealed long nails on all fingers except the ring finger. LVN F stated they were about an inch and a half long and needed to be trimmed. LVN F attempted to open Resident #6's right hand and stated the nails needed to be cut. Observation and interview on 07/29/26 at 11:45 AM in Resident #6's room, revealed OT N and PTA R provided therapy to Resident #6, with the DOR present. OT N was working on moving Resident #6's arms and stated he had been more contracted since he had been back from the hospital [in April 2026] and they were trying to maintain his ROM. OT N stated as far as splinting, it would rest against his thumb and could cause a wound. The OT stated if she noticed any skin issues she would tell the Wound Care Nurse. The OT stretched and moved Resident #6's right arm to show the offloading device would fit onto his wrist. The DOR stated she in-serviced nursing on where to place positioning devices and to use a pillowcase in the hands or between his arm and chest. The DOR stated the aides would be responsible to place the pillowcases or devices and she did not think an order was needed for offloading devices since it would be the same as a wedge. Interview on 07/29/26 at 12:10 PM, CNA K stated she had worked with Resident #6 for about a week. She stated she used towels in his hands and in between his arms or the blue offloading device. She stated there were boots for his feet. Interview by phone on 07/29/26 at 12:34 PM with CNA S was unsuccessful, a voicemail was left. In a follow-up interview on 07/29/26 at 1:10 PM, LVN I stated staff reported to her if they found any new skin issues. She stated she would then assess the resident and call the wound doctor, get a new order for treatment. She stated usually carrots were used for contracture management, but Resident #6's hands were so tight a carrot would not fit so they were to use foam or a washcloth to relieve pressure. She stated she did not realize his [right] hand was pushing up against his chest as much as it was before he developed the wound to the right palm. She stated the risk of not using the washcloths or something to decrease the pressure was first, the contracture could get worse and second the pressure from his own body could cause an opening. Interview on 07/29/26 at 1:29 PM, via phone, with CNA O revealed she had only worked with Resident #6 for the past week or two. She stated she put washcloths in his hands and an offloading device on his wrists to keep his hand from touching his skin. She stated CNAs were responsible for cleaning Resident #6's hands and reporting any skin issues to the nurse or the wound care nurse. Interview on 07/29/26 at 1:37 PM, the Wound Care Physician stated Resident #6 was very (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Actual harm Residents Affected - Few	contracted, moved in a ball, and was contracted in his hands. She stated clipping his nails was difficult and he had developed a wound [that had since healed]. She stated developing wounds was unavoidable because he was rigid, and it would be impossible to offload, however she could not deny that there could have been more done to prevent the wound on the right palm. She stated when residents were that contracted, she would let therapy decide on how to offload. Interview on 07/29/26 at 3:02 PM, CNA P stated she has worked at the facility for 4 years and 7 months. CNA P stated she worked with Resident #6 and was his aide yesterday and gave him a shower yesterday. She stated he had been very contracted for a long time and would try to clean under his fingers when he showered, but she could not open his hands up, so she cleaned mostly the outside of the hands. CNA P stated she did not put anything in his hands but sometimes the nurse would do that. She stated sometimes she would put a pillow between one hand because he would bleed. She stated he would have the blue brace sometimes when therapy put it on and she would put it back on after a shower, but would not put it on if he was not wearing it. She stated he did not have anything on yesterday, not the brace or washcloths. Interview on 07/30/26 at 3:00 PM, RN Q stated Resident #6 had contractures and nurses and aides were responsible for putting washcloths in the palm and underneath his hand to prevent friction. She stated aides were supposed to clean his hands daily and ensure that there was no skin breakdown. Observation and interview on 07/30/26 at 3:14 PM in Resident #6's room, revealed LVN I and RN J were performing wound care treatment to the right palm. Resident #6 was turned on his right side so RN J could hold his arms while LVN I provided the wound care. The wound bed was pink, measured approximately 1x1 inch with skin intact and no signs of infection noted. The dressing on Resident #6's left hip was not dated. LVN I stated she had put the dressing on yesterday with the Wound Care Physician and did not date it because she forgot her marker. She stated she was supposed to date and initial the dressing and the risk of not doing that was the dressing could be left on there too long. She stated she documented on the TAR when the dressing was changed. Interview on 07/30/26 at 4:42 PM, ADON A stated CNAs were responsible for applying washcloths and offloading devices and the nurses were to make sure they were in place for Resident #6. She stated if not done the risk to the resident would be further wounds could develop. ADON A stated wound dressings should be dated by whoever provided the treatment. She stated it was important to date the dressings so it could show when it was done, and if not the resident could be at risk of infection and the wound getting worse. Interview on 07/30/26 at 6:00 PM, the DON stated they were managing Resident #6's contractures the best they could by putting pillowcases, and towels in his hands and the round foam device on his wrists. She stated CNAs, and nurses could attempt and if they had trouble getting them in his hands, they could go to therapy to try to get them in. She stated the washcloth was to soak up moisture, so yeast did not develop and try to keep his skin integrity. The DON stated Resident #6's hands should be cleaned daily and the washcloths should be changed daily. She stated if staff noticed any odor or change it should be reported to the nurse by the aides. The DON stated her expectation was that all wound dressings and bandages should be dated and initialed so they would know when they were done. The DON did not answer when asked what the risk to the resident was. Interview on 07/30/26 at 6:57 PM, the Interim Administrator stated nursing staff was responsible for applying offloading devices. He stated the risk of not managing Resident #6's contractures was he could develop wounds and have a decline in his well-being. Review of facility Skin Prevention and Management Guidelines revised 04/13/2023, reflected in part: Management.therapeutic exercises: incorporate therapeutic exercise into the resident's daily routine, including both passive and active range-of-motion exercises to maintain or improve joint mobility.orthopedic devices: utilize orthopedic devices such as splints or braces, to support proper joint alignment and prevent further contracture development.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 provide a clean, safe, and functional environment for 1 of 8 rooms (room [ROOM NUMBER]) and 2 of 2 halls (Station 1 and Station 2) reviewed for environment. 1. The facility failed to repair the blinds in Resident #27's room. 2. The facility failed to ensure there was not a foul odor that lingered into the hall from the soiled utility room in Station 1 hall. 3. The facility failed to ensure there was not a strong urine odor in Station 2 hall near Resident #28, Resident #16 and Resident #85's rooms. These failures could place residents at risk of living in an unsanitary, unsafe environment and a diminished quality of life. Findings included: Observation and interview on 07/28/2026 at 11:34 AM, in Resident #27's room, revealed a red and green blanket hanging up covering the left side of the window. Vertical blinds were missing behind the blanket. Resident #27 stated the blanket hanging up and broken blinds did not bother him. Observation on 07/28/2026 at 3:00 PM revealed a staff member opened the door to the soiled utility room on Station 1 to put away soiled linen and trash. A foul odor was noted once the door opened and lingered in the hallway. Observation on 07/28/2026 at 2:41 PM, on Station 2 hallway, revealed a strong urine odor in the hallway between Resident #28, Resident #16 and Resident #85's rooms. Interview on 07/30/26 at 3:38 PM, the Maintenance Director stated he had worked at the facility for 6 weeks. He stated he expected staff to tell him if repairs were needed or to put needed repairs in the [name of building management software]. Interview on 07/30/26 at 5:15 PM, ADON B stated she noticed an odor on Station 2 hallway. She stated a resident would change herself and throw wet briefs and linens on the floor. She stated nursing staff would pick up the linens and trash and get housekeeping to clean the room. She said if it happened during the night shift, nursing staff would mop the floor. She stated if urine was spilled on the floor in the bathroom, it could cause the odor. She stated the smell could make some residents nauseas and it would be nasty. Interview on 07/30/26 5:35 PM, the Housekeeping Supervisor stated resident rooms, soiled utility rooms and hallways were cleaned by housekeeping staff. She stated if any BM or urine was in the rooms the CNA would clean it first, then the housekeeping staff would go in and sanitize. She stated she noticed the urine odor in Station 2 hallway and said one of the residents did not like to wear briefs and went to the bathroom and did not allow housekeeping to clean the room. She stated another room on the same hall had a resident who would urinate and put the urine in the trash can. She stated some residents urinated on the floor in the bathroom which caused the odor near Resident #48's room. She stated they were not allowed to use bleach or air fresheners and used the chemicals they were provided. She stated the risk to residents was it could be a hazard because it was urine and it stinks. The Housekeeping Supervisor stated she expected her staff to report to her and to Maintenance if any repairs were needed in resident rooms. She stated Resident #27's blinds needed to be replaced, they had been broken for three to four months and new ones were ordered. She stated if repairs were not done residents could feel like they were not taken care of. Interview on 07/30/26 at 6:00 PM, the DON stated she noticed the urine odor on Station 2 hallway some days. She stated housekeeping was supposed to clean, but if something had feces or urine on it the nursing staff was to clean it first and then they would get housekeeping to sanitize. She stated housekeeping mopped frequently and they were not allowed to use aerosols. The DON stated she did not know if the urine odors would pose a risk to residents, but it could make them unhappy. She stated her expectation was for staff to report to Maintenance if repairs were needed in resident rooms. She stated the risk could be making (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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	Resident #27 unhappy. Interview on 07/30/26 at 6:57 PM, the Interim Administrator stated blinds were ordered for Resident #27's room. He stated staff should report needed repairs or cleaning to Maintenance or Housekeeping. He stated the odors and broken blinds could affect residents by not creating a nice environment to live in and could be unsanitary. Record review of facility Resident Rights policy, dated 2/20/2021, reflected the following: .8. Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	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** Based on observations, interviews, and record review the facility failed to ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain grooming and personal care for 2 of 16 residents (Residents #26 and #6) reviewed for ADL care. The facility failed to ensure nail care, to include trimming, was provided to Residents #26 and #6, observed on 7/28/26, 7/29/26, and 7/30/26. The failure placed the residents at risk of hygiene and safety risks such as nail tearing, injury, and functional difficulties. Findings included: 1. Record review of Resident #26's Face Sheet, dated 07/30/26, reflected a [AGE] year-old male who admitted on [DATE]. Record review of Resident #26's Quarterly MDS, dated [DATE], reflected the resident had diagnoses that included: Cerebral Infarction (stroke caused by blocked blood flow), Vascular Dementia (cognitive impairment caused by lack of blood flow), Aphasia (brain disorder that affects how you speak, understand, read, and write), and Diabetes Mellitus (chronic condition in which the body does not regulate blood sugar levels). The MDS reflected that Resident #26 was dependent (requires full assistance of staff) for all ADLs and had severe cognitive impairment. Record review of Resident #26's Care Plan, undated, reflected the resident had an ADL self-care performance deficit with interventions that he required extensive assistance with ADLs and to, Provide shower, shave, oral care, hair care, and nail care per schedule and when needed. The care plan also reflected he had a diagnosis of Diabetes. Record review of Resident #26's July 2026 progress notes revealed no documentation of refusal of fingernail care. Observation on 07/28/2026 at 2:37 PM reflected Resident #26 was sitting in a recliner chair watching TV. His fingernails were observed to be approximately 1/2 inch long with jagged, sharp edges. Resident #26 could not answer any questions about his fingernails or preferences when interviewing. Observation on 07/29/2026 at 10:49 AM reflected Resident #26 was sitting in the dining room in his chair. His fingernails were observed to be 1/2 inch long with jagged edges. The resident was clean with damp hair and appeared to have received a shower. Resident #26 was not interviewable and did not answer any questions about his fingernails. Observation on 07/30/2026 at 12:46 PM revealed Resident #26 sitting in the dining room after lunch. His fingernails were observed to be approximately 1/2 inch long with sharp corners and edges. Interview and observation on 07/30/2026 at 12:48 PM with CNA G revealed she worked regularly with Resident #26. During the interview, CNA G observed Resident #26's nails and stated his nails were very long and needed to be trimmed. CNA G stated Resident #26 was a diabetic, so she did not cut his (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	nails. She stated LVN H knew his nails were long because she made a comment the previous day, 07/29/26, during his blood sugar check that she was going to trim them. CNA G stated LVN H was busy and must not have had time to trim them. CNA G stated she did not notify any nurses about Resident #26's long nails and that he did not refuse any nail trims that she was aware of. CNA G stated the risk of long nails was the resident scratching himself. Interview on 07/30/2026 at 12:52 PM with LVN H revealed that she had worked at the facility for 2 years and was Resident #26's nurse. LVN H stated Resident #26's nails were long and that she noticed how long they were this morning, but that no one had notified her previously. LVN H stated she was responsible for cutting his nails since he was a diabetic resident, but she had not got to it yet. LVN H stated his nails were cut last month but was unable to recall the date. She stated the risk of Resident #26 having long nails was he could scratch himself and cause harm. 2. Record review of Resident #6's Significant Change MDS, dated [DATE], reflected he was a [AGE] year-old male with an original admission date of 05/22/24 and readmission date of 04/29/26. Resident #6's diagnoses included stroke, Hemiplegia (partial paralysis of one side of the body) or Hemiparesis (weakness on one side of the body) and Encephalopathy (any disease, damage, or malfunction of the brain that causes altered mental function). Resident #6's BIMS score was blank and cognitive skills were severely impaired. Record review of Resident #6's care plan, dated 05/23/24 reflected Resident #6 had an ADL self-care performance deficit and was dependent on staff for all ADLs. Record review of Resident #6's progress notes from 05/25/26 to 07/29/26 revealed no entries that nail care was provided or attempted. Observation on 07/28/2026 at 3:00 PM, revealed Resident #6 was lying in bed. The , resident was not able to answer questions. Resident #6's left hand appeared contracted, and the thumb nail was long. Observation and interview on 07/29/2026 at 11:33 AM, LVN F stated the nurse was responsible for cutting Resident #6's nails and said he cut them a couple of weeks ago. He stated CNAs were to clean Resident #6's hands and if they were not cleaned, he could develop skin issues or wounds. LVN F put on gloves and turned Resident #6's right hand which revealed long nails on all nails except the ring finger. LVN F stated they were about an inch and a half long and needed to be trimmed. LVN F attempted to open Resident #6's right hand and stated the nails needed to be cut. Interview on 07/30/2026 at 4:19 PM with ADON A revealed she had been an ADON at the facility for 1 year. She stated she expected the CNAs to observe the residents' nails every shower day and trim and clean them when needed. ADON A stated if they were a diabetic resident, the nurses were responsible for trimming their nails. ADON A stated the nurse should cut Resident #6's nails. ADON A stated if the residents had long nails, the risk was self-injury and infection control issues. Interview on 07/30/2026 at 5:00 PM with ADON B revealed she had been an ADON for 3-4 years. She stated she was the ADON over Resident #26. ADON B stated she expected the residents to have short and clean nails if that was what they wanted. ADON B stated the nurses were responsible for (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	ensuring the nails were trimmed if the resident was a diabetic. She stated she had seen Resident #26's nails when he was eating and that they were long. ADON B stated the long nails could cause skin tears and infections. Interview on 07/30/2026 at 5:43 PM with the DON revealed she expected the staff to complete nail care when the residents needed it. She stated the aides were supposed to check on shower days and daily as needed. The DON stated the nurses were responsible for completing diabetic resident nail trims. She stated she was familiar with Resident #26 but had not seen his long nails. The DON stated the risk of long nails was the residents scratching themselves and causing an infection. The DON stated the nurse should cut Resident #6's nails, and CNAs should inform the nurse if his nails were long. She said if they were left long they could injure his skin. Interview on 07/20/26 at 6:58 PM with the Interim Administrator revealed that he expected the residents' nails to be cut when they were needed. He stated the nursing team was responsible for ensuring nail care was completed. The Interim Administrator stated the risk of long nails was the residents cutting themselves and injury. Record review of facility Activities of Daily Living Care Guidelines policy, dated 01/23/16, reflected the following: A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for 1 of 1 resident (Resident #6) reviewed for range of motion. The facility failed to implement interventions to prevent further decline of Resident #6's contractures to right and left hands and arms. The failure could place residents at risk for decline in range of motion, decreased mobility, pain, and worsening of contractures. Findings included:Record review of Resident #6's Significant Change MDS, dated [DATE], reflected he was a [AGE] year-old male with an original admission date of 05/22/24 and readmission date of 04/29/26. Resident #6's diagnoses included stroke, Hemiplegia (partial paralysis of one side of the body) or Hemiparesis (weakness on one side of the body) and Encephalopathy (any disease, damage, or malfunction of the brain that causes altered mental function). Resident #6's BIMS score was blank, and cognitive skills were severely impaired. Resident #6 had upper and lower extremity impairment on both sides and was dependent for all ADLs.Record review of Resident #6's care plan, revealed the following:-Resident #6 had an ADL self-care performance deficit and was dependent on staff for all ADLs, Date initiated 05/23/24.-Resident #6 had the potential for the development of a pressure ulcer, Date initiated 07/20/25 with interventions that included pressure relieving/reducing devices on bed/chair.reposition frequently.-Resident #6 at risk for impaired skin integrity r/t contractures in all extremities, Date initiated 09/12/25 with interventions that included use circular limb off loader to keep hand from resting against other body parts. utilized pillows or foam wedges to avoid direct contract with bony prominences.utilize pressure relieving devices on appropriate surfaces.-Resident #6 had alteration in musculoskeletal status r/t contractures of all moveable joints, Date Initiated 12/01/25 with interventions that included Range of Motion weekly by therapy dated 02/18/26, and Wash cloth right thumb and index finger. Wash cloth against shoulder and hand on right. Change wash clothes daily dated 02/18/26. Record review of Resident #6's order summary reflected the following:- Skilled Occupational Therapy services for PASSR services 1xs for 90 days for self-care, ADL retraining,therapeutic activities, therapeutic exercises, neuromuscular re-education, and manual therapy, and safety education order date 6/09/26- Skilled Physical therapy for 1X/WK FOR 90 days for PASRR services order date 06/09/26- Speech therapy: Skilled Speech/Language treatment 1x/wk x 90 days for PASRR services order date 06/08/26Observation on 07/28/2026 at 3:00 PM, revealed Resident #6 lying in bed, resident was not able to answer questions. Resident #6's left hand appeared contracted and thumb nail was long. No offloading device was observed on Resident #6's arm or wrist.Observation on 07/29/26 at 9:24 AM, revealed Resident #6 lying in bed, bordered gauze was on the right palm, no wash clothes or offloading device was observed in or around the hands or wrists. CNA K was in the room to check if Resident #6 needed to be changed. Interview on 07/29/26 at 9:55 AM, LVN I stated Resident #6 was severely contracted. She stated he had wedges and repositioning devices and a device that was round that fit around the arm to help lift it. She stated the CNAs were responsible for putting them on and Resident #6 was supposed to wear them all the time. Observation on 07/29/26 at 10:07 AM, revealed Resident #6 lying in bed, no wash clothes or offloading device was observed in or around the hands or wrists. A blue round offloading device was observed in the wheelchair.Interview on 07/29/26 at 10:08 AM, CNA L stated he usually worked nights and stated Resident #6 was contracted and had not seen the blue offloading device before. He (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated when he cleaned Resident #6's hands sometimes he would fold a towel and place it in his hands and he would grip it. He stated therapy and the wound care nurse checks on him. Interview on 07/29/26 at 10:15 AM, LVN F stated Resident #6 did not have an order for an offloading device but he saw therapy go in and apply it to Resident #6's wrists. He stated he did not get instructions Resident #6 was supposed to wear it all the time. Interview on 07/29/26 at 11:06 AM, the DOR stated Resident #6 was currently receiving PT, OT and ST through PASARR one time a week for each. She stated Resident #6 does not stretch enough to use a splint and they try to stretch out the contractures, but Resident #6 could not tolerate a splint. Observation and interview on 07/29/26 at 11:45 AM in Resident #6's room, OT N and PTA R provided therapy to Resident #6, with DOR present. OT N was working on moving Resident #6's arms and stated he had been more contracted since he had been back from the hospital [in April 2026] and they were trying to maintain his ROM. OT N stated as far as splinting, it would rest against his thumb and could cause a wound. The OT stated if she noticed any skin issues she would tell the wound care nurse. The OT stretched and moved Resident #6's right arm to show the offloading device would fit onto his wrist. The DOR stated she in- serviced nursing on where to place positioning devices and to use a pillowcase in the hands or between his arm and chest. The DOR stated the aides would be responsible to place the pillowcases or devices and she did not think an order was needed for offloading devices since it would be the same as a wedge. Interview on 07/29/26 at 12:10 PM, CNA K stated she had worked with Resident #6 for about a week. She stated she used towels in his hands and in between his arms or the blue offloading device. She stated there were boots for his feet. Interview on 07/29/26 at 12:34 PM with CNA S was unsuccessful, a voicemail was left. In a follow-up interview on 07/29/26 at 1:10 PM, LVN I stated usually carrots were used for contracture management, but Resident #6's hands were so tight a carrot would not fit so they were to use foam or a washcloth to relieve pressure. She stated the risk of not using the washcloths or something to decrease the pressure was first, the contracture could get worse and second, the pressure from his own body could cause an opening. Interview on 07/29/26 at 1:29 PM, via phone, with CNA O revealed she had only worked with Resident #6 for the past week or two. She stated she put washcloths in his hands and an offloading device on his wrists to keep his hand from touching his skin. Interview on 07/29/26 at 3:02 PM, CNA P stated she has worked at the facility for 4 years and 7 months. CNA P stated she worked with Resident #6 and was his aide yesterday and gave him a shower yesterday. She stated he had been very contracted for a long time and would try to clean under his fingers when he showered, but she could not open his hands up, so she cleaned mostly the outside of the hands. CNA P stated she did not put anything in his hands but sometimes the nurse would do that. She stated sometimes she would put a pillow between one hand because he would bleed. She stated he would have the blue brace sometimes when therapy put it on and she would put it back on after a shower, but would not put it on if he was not wearing it. She stated he did not have anything on yesterday, not the brace or washcloths. Interview on 07/30/26 at 3:00 PM, RN Q stated Resident #6 had contractures and nurses and aides were responsible for putting washcloths in the palm and underneath his hand to prevent friction. Interview on 07/30/26 at 4:42 PM, ADON A stated CNAs were responsible for putting washcloths and offloading devices on Resident #6 and the nurses were to make sure they were in place for Resident #6. She stated if not done the risk to the resident would be the worsening of contractures. Interview on 07/30/26 at 6:00 PM, the DON stated they were managing Resident #6's contractures the best they could by putting pillowcases, and towels in his hands and the round foam device on his wrists. She stated CNAs, and nurses can attempt and if they had trouble getting them in his hands, they could go to therapy to try to get them in. She stated the washcloth was to soak up moisture, so yeast did not (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	develop and try to keep his skin integrity. The DON stated Resident #6's hands should be cleaned daily and the washcloths should be changed daily. She stated if staff noticed any odor or change it should be reported to the nurse by the aides. The DON did not answer when asked what the risk was. Interview on 07/30/26 at 6:57 PM, the Interim Administrator stated nursing staff was responsible for applying offloading devices. He stated the risk of not managing Resident #6's contractures was he could develop wounds and have a decline in his well-being. Review of Inservice dated 02/18/26 presented by OT N and PTA R reflected Resident #6 Wedge laterally and rotate every 2 hours. Contracture management for BUE/LEs.[sic] Review of facility Contracture Management dated 02/01/25, reflected in part: This facility is committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injuries. 'Avoidable' means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: . implement interventions that are consistent with resident needs, resident goals, and professional standards of practice. 3. Interventions for Prevention and to Promote Healing c.i. Redistribute pressure. ii. Minimize exposure to moisture and keep skin clean. skin care intervention such as showers. repositioning devices/schedule and adaptive devices, etc., are used to reduce the risk of pressure injury development.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for 3 of 6 residents (Residents #7, #10, #62) reviewed for accidents and supervision. 1.The facility failed to ensure Residents #10 was covered with a smoking apron while being supervised during smoking breaks. 2.The facility failed to ensure Residents #7, #10, and #62 received quarterly smoking assessments. These deficient practices could place residents at risk for burns causing injury or harm. Findings included: Review of Resident #7's MDS dated [DATE] indicated Resident #7 was a [AGE] year-old male admitted to the facility on [DATE]. Resident #7 had a BIMS of 06 indicating severe cognitive impairment. Resident #7 had a diagnoses that included Anxiety Disorder (excessive, uncontrollable worry about everyday issues, affecting daily function and quality of life), Bipolar Disorder (elevated mood, increased energy, and decreased need for sleep, while depressive episodes can lead to feelings of sadness, hopelessness, and loss of interest in activities), Schizophrenia (a severe, chronic brain disorder that affects how a person thinks, feels, and acts), Respiratory Failure (when your respiratory system cannot bring enough oxygen into your blood or get rid of enough carbon dioxide), lack of coordination. Record review of Resident #7's undated care plan revealed: [Resident #7] is a smoker and is at risk for injury. Resident is dependent on staff for smoking. Goal: [Resident #7] will abide by facility's smoking policy and remain safe during times. Interventions included Dependent Smoker: This resident is a dependent smoker and required staff supervision to reduce the risk for smoking related injuries. Independent Smoker: Resident is an independent smoker and does not require the use of a smoking apron or direct staff supervision during smoking breaks. Perform smoking assessment according to facility policy. Safety tubed ashtray device for safety of burn prevention. Resident #7 did not have a smoking assessment [BR51.1] in his clinical chart. Observation and interview on 07/29/26 at 3:40 PM with Resident #7 revealed him outside during a smoking break with a tubing device, with one end of a tube in his hand to administer to his mouth and the other end connected to a lit cigarette. The cigarette was observed to drop ashes to an ashtray that was connected to her wheelchair. Resident #7 indicated he was required to use the tube (smoking apparatus) by pointing to the aide during smoke break waiting on her to provide the tube. Review of Resident #10's MDS dated [DATE] indicated Resident #10 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #10 had a diagnoses that included stroke (sudden interruption of blood flow to the brain), Non-Alzheimer's Dementia (conditions that impair memory, cognition, and daily functioning), Parkinson's Disease (affects movement, balance, tremors), Anxiety Disorder (excessive, uncontrollable worry about everyday issues, affecting daily function and quality of life), Bipolar Disorder (elevated mood, increased energy, and decreased need for sleep, while depressive episodes can lead to feelings of sadness, hopelessness, and loss of interest in activities), Psychotic Disorder (state of having difficulty distinguishing what is real from what is not), Post Traumatic Stress Disorder (intrusive thoughts, avoidance behaviors, negative changes in mood and cognition), and Chronic Obstructive Pulmonary Disease (progressive lung disease that makes it difficult to breathe, primarily caused by long-term exposure to irritants like cigarettes smoke and air pollution), muscle weakness Review of Resident #10's undated care plan revealed: [Resident #10] is a smoker and is at risk for injury. Dependent Smoker. [Resident #10] is a dependent smoker and required staff supervision to reduce the risk for smoking related injuries. Goal: [Resident #10] will abide by (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility's smoking policy and remain safe during times. Interventions included assist resident to and from smoking area as needed. Perform smoking assessment according to facility policy. Remind family of need for smoking apron for unsafe smoker and that they must remain with the resident when smoking to prevent injury. Residents use a smoking apron during smoke breaks. Staff to provide direct supervision to unsafe smokers. Resident #10's care plan did not express the use or requirement of a smoking apparatus. Resident #10 did not have a smoking assessment [BR52.1]in her clinical chart. Observation and interview on 07/29/26 at 3:40 PM with Resident #10 revealed her outside during a smoking break with an apron across the front of her body. Resident #10 had a tubing device, with one end of a tube in her hand to administer to her mouth and the other end connected to a lit cigarette. The cigarette was observed to drop ashes to an ashtray that is connected to her wheelchair. According to Resident #10 she was required to use the apron and tube (smoking apparatus) if she wanted to smoke. Resident #10 expressed staff assisted her to the smoking patio, provided an apron and the smoking apparatus during each smoking break. Review of Resident #62's MDS dated [DATE] indicated Resident #62 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #62 had a diagnosis that included high blood pressure, high blood sugar, Anxiety Disorder (excessive, uncontrollable worry about everyday issues, affecting daily function and quality of life), Bipolar Disorder (elevated mood, increased energy, and decreased need for sleep, while depressive episodes can lead to feelings of sadness, hopelessness, and loss of interest in activities), Psychotic Disorder (state of having difficulty distinguishing what is real from what is not), Schizophrenia (a severe, chronic brain disorder that affects how a person thinks, feels, and acts), Respiratory Failure (when your respiratory system cannot bring enough oxygen into your blood or get rid of enough carbon dioxide), nicotine dependence (chronic, relapsing condition where the body and brain become reliant on nicotine). Review of Resident #62's undated care plan revealed: [Resident #62] is a smoker and is at risk for injury. [Resident #62] will have behaviors when she is out of cigarettes. Goal: Resident will abide by facility's smoking policy and remain safe during times. Interventions included Independent Smoker: Resident is an independent smoker and does not require the use of a smoking apron or direct staff supervision during smoking breaks. Perform smoking assessment according to facility policy. Resident #62 did not have a smoking assessment [BR53.1]in her clinical chart. Observation and interview on 07/29/26 at 3:40 PM with Resident #62 revealed her outside during a smoking break with a cigarette. Resident #62 appeared to be a safe smoker with cigarettes. Resident #62 was able to maintain her cigarette after the CNA C lit it and was able to properly use an ashtray to prevent any dropped ashes or burns. Resident #62 expressed staff held cigarettes in a box and issued two cigarettes during each smoke break. According to Resident #62 she was able to smoke without an apron or smoking tube, she was not sure if she had ever completed a smoking assessment. Observation and interview on 07/30/26 at 3:44 PM with CNA C revealed 7-8 residents on the patio during a smoking break. Resident #7 was on the patio observed with a smoking tube (smoking apparatus) in his hand waiting to have a cigarette administered to the end of the tube. Resident #10 on the patio holding a smoking apparatus in her hand, administering it to her mouth for smoking. Resident #10 was not wearing an apron as it was on the ground underneath the table where CNA C was standing. [BR54.1][JT54.2]Resident #62 was sitting in her rollator smoking on a cigarette, another cigarette in her hand, and asking for her vape. Resident #62 indicated her vape was not working and would like to have it charged for the next smoke break. According to CNA C, all residents required supervision however, both Resident #7 and Resident #10 required a smoking tube which connected the tube to the cigarette, the cigarette was mounted to the ashtray, which was attached to their wheelchair. According to CNA C the apparatus prevented any ashes dropping on their (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	body or clothing. CNA C stated Resident #62 did not require a smoking tube because she was an independent smoker. When CNA C was asked about Resident #10's smoking apron, she stated Resident #10 did not have to use the apron as long as she used the smoking tube. CNA C further stated smoking assessments for residents, she stated nurses were responsible for completing the smoking assessments. CNA C stated she had training to supervise residents during smoking breaks which included which residents required supervision. CNA C stated staff who took residents out to smoke were responsible for supervising residents and administering any protective equipment. CNA C stated not properly supervising residents placed them at risk of burn injuries. Interview on 07/30/26 at 6:00 PM with Social Worker revealed she completed smoking contracts and educated residents on the facility policy for smoking. The Social Worker stated she had not completed any smoking assessments with residents, she had only completed the smoking contracts. The Social Worker stated the smoking contracts were completed in March or April 2026 before the new company took over. The Social Worker stated she was not aware of who was responsible for completing the smoking assessments for residents that smoked. The Social Worker stated all contracts were uploaded in the old system to be transferred into the new system. The Social Worker stated she had not reviewed resident charts to ensure the smoking contracts were there and could not provide copies at this time. According to the Social Worker, not providing smoking assessments placed residents at risk of injury if was not aware of the required safety measures. Interview on 07/30/2026 at 6:35 PM the DON stated all staff that assisted residents with smoking were aware that Resident #7 required a smoking apparatus, Resident #10 required protective equipment that included a smoking apron or smoking apparatus. The DON stated Resident #10 now used a smoking apparatus, which did not require the use of an apron[BR55.1][JT55.2]. The DON expressed that Resident #62 was an independent smoker and did not require either. The DON further expressed all staff were responsible for ensuring residents were supervised during smoking breaks with appropriate protective equipment. The DON stated smoking assessments were to be completed quarterly, which were every 3 months. The DON stated when the facility was acquired by a new company, new smoking contracts and new smoking assessments were completed, however they may not have been transferred into the new system. The DON stated she could not locate the assessments as they were all uploaded to the system with the expectation of the documents transferring properly with the new company in April 2026. [BR56.1]The DON stated the Social Worker was responsible for ensuring smoking assessments were completed quarterly, not doing so placed residents as risks of smoking injuries. Record review of the facility Smoking Policy - Residents policy, revised 07/14/23, reflected: It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees as related to smoking. To evaluate a patient's ability to participate and exercise the privilege to smoke/Use smokeless Tobacco products while residing within the facility. Evaluate patients that smoke/use smokeless tobacco, utilizing the Smoking Evaluation/Smokeless Tobacco Tool: (a) upon admission; (b) quarterly (c) when a previous non-smoking patient takes up smoking or when a patient takes up the use of smokeless tobacco (d) if unsafe smoking practices are observed in a current smoker; or a smokeless Tobacco user can no longer manage the use of, or cleaning/storage abilities (e) when a patient that smokes or uses smokeless Tobacco products has a significant change in medical condition. Request therapy screen as indicated. Education will be provided to the resident on the assessment and the facility's expectation of compliance with the smoking program. Residents who smoke/use smokeless tobacco, will sign a smoke agreement upon admission and will be required to follow rules and regulations.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety.in the facility's only kitchen. 1. The facility failed to ensure a large piece of meat stored in the refrigerator was properly sealed and stored to prevent liquid from spilling over other food items that were not properly sealed, labeled or dated.2. The facility failed to ensure staff that worked or entered the kitchen wore and maintained proper use of hair nets.This failure could place all residents at risk for food contamination and food borne illness. Findings included: Observation and interview on 07/28/26 at 9:00 AM with [NAME] D of the refrigerator revealed a sheet pan with a large piece of meat wrapped in plastic, lightly covered by a piece of foil. The sheet pan was observed to be tilted on food item that [NAME] D revealed to be unsealed, unlabeled, or undated bacon wrapped in white parchment paper. The parchment paper had red ring stains indicating that liquid from the sheet pan had leaked creating a puddle at the bottom of the refrigerator. According to [NAME] D she did not know how long the meat had been in the refrigerator. [NAME] D stated the Dietary Manager was responsible for completing daily walks throughout the refrigerator to ensure food was properly sealed, labeled and dated. [NAME] D further stated the Dietary Manager was responsible for cleaning out the refrigerator when spills happened. [NAME] D stated when food was not properly stored it placed residents at risk of getting sick. Observation and interview on 07/29/26 at 11:30 AM in the kitchen revealed the Maintenance Assistant entered the kitchen without providing any hand hygiene. The Dietary Manager advised the hair nets were behind him. The Maintenance Assistant turned around to administer a beard net to his head, which included a long ponytail. According to the Maintenance Assistant, he was not aware of how to administer the hair net. The Maintenance Assistant was advised the hair net was for his beard, he then stepped outside the kitchen to administer the proper hair net. Observation revealed he did not cover his entire head of hair while in the kitchen, leaving out his ponytail that measured at least 12 inches long from the back of his neck. The Maintenance Assistant returned to the kitchen without any hand hygiene and stood near staff preparing resident's dessert [VT74.1]for the lunch trays. Interview with the Maintenance Assistant revealed he did not think the beard net was the right hair net, so he went outside the door to get a proper hair net. The Maintenance Director stated he was aware to use the hair nets while in the kitchen. According to the Maintenance Assistant, he just forgot to use hand hygiene after entering the kitchen, not doing so placed residents at risk of contamination and food illnesses. Interview on 07/29/26 at 12 PM with the Dietary Manager revealed she noticed the leaking in the refrigerator when she entered the facility on 07/28/26. The Dietary Manager revealed she had been trying to rearrange the refrigerator, to have one side for thawing to prevent situations like leakages. According to the Dietary Manager, the cooks were in charge when she was not working and she expected all staff and the cooks to complete daily walk-throughs to ensure food was properly sealed, labeled and dated. The Dietary Manager stated [NAME] D should have observed the spill and open food upon the start of her shift and removed the open bacon and discarded it; the leakage at the bottom of the refrigerator should have been cleaned. The Dietary Manager stated these conditions placed residents at risk of contamination and illness. The Dietary Manager further expressed that she did advise the Maintenance Assistant to administer a hair net but did not see that he tried to use the beard net for his head. The Dietary Manager stated the Maintenance Assistant entered the kitchen during lunch rush, so she did not notice he did not wash his hands and administered the hair net incorrectly. The Dietary Manager stated she expected all staff (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	entering the kitchen to use proper hygiene, which included hair nets and washing their hands, not doing so placed residents at risk of food born illnesses due to food contamination. Food Storage Policy was requested, however, it was not provided by exit date. Review of the facility's Personal Hygiene policy, revised 10/24/22, reflected: Dietary employees will maintain proper food safety practices through proper personal hygiene. Proper hand washing techniques and exclusion of infectious individuals from handling food are critical for prevention of foodborne illness. Dietary employees shall wear, hair covering, beard restraint, and clothing that covers body hair. Staff that work serving in the dining room do not need to wear hair restraints. Any staff entering the kitchen must comply with hair restraints and hand washing.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to ensure the facility was free of pests and rodents for 1 of 2 halls (Station 1), Resident #6's room, and 1 of 1 kitchen reviewed[VT69.1] for pest control. The facility failed to ensure Station 1 hall and the kitchen were free from pests. This failure could place residents at risk for the potential spread of infection, cross-contamination, and decreased quality of life. Findings included: Observation on 07/29/26 at 9:20 AM on Station 1 hallway, revealed 2 flies flying and landed on wall near the soiled utility room. Interview and observation on 07/29/26 at 11:40 AM in the kitchen revealed 3-5 flies on the snack box and another 4-5 flies flying around the kitchen. According to the Dietary Manager, she was aware of the fly problem in the kitchen, she stated it was due to the back door not having a proper seal to close off the door properly. The Dietary Manager stated the Administrator was aware and in the process of purchasing a blower over the door to keep flies from entering the back door to the kitchen. According to the Dietary Manager all staff were responsible for ensuring the door is closed at all times to prevent flies from entering the kitchen. The Dietary Manager stated not doing so will place residents at risk of food contamination. Observation and interview on 07/29/26 at 3:14 PM, in Resident #6's room during wound care, revealed a fly flying around in the room around Resident #6, who was in bed. Resident #6 was not able to answer questions. RN J said she noticed the fly in the room and said if they saw pests they were to write it down for the exterminator. She stated she had noticed flies in common areas and they would shoo them away from residents. Interview on 07/28/26 at 3:38 PM, the Maintenance Director stated he had been there 6 weeks. He stated he had noticed flies and they were working on the door curtains and new doors for the kitchen. He stated staff were to write any sightings in the pest control book and when pest control did come out, they would treat those areas. Interview on 07/28/26 at 4:16 PM, the Interim Administrator stated they were trying to address the pest control issue and a new frame and door were approved to be replaced in the kitchen. He stated there was an air curtain outside the kitchen door and they had ordered two new ones but had some issues getting them up due to electrical problems. The new air curtains were for the kitchen and the smoking area. He stated the flies were coming in when staff took people to smoke. Interview on 07/28/26 at 6:00 PM, the DON stated flies could irritate the residents and they had pest control come out to treat some resident rooms for flies. She stated her expectation was for staff to write down any pest sightings or alert Maintenance. She stated the risk to residents would be infection control. Interview on 07/28/26 at 6:57 PM, the Interim Administrator stated the risks to residents were flies and pests could potentially carry disease and it could be unclean and undignified for the residents. [Vendor Name] pest services inspection reports reflected the following:- Report dated 06/09/26 reflected, in part, Recommendations: Repair or replace the kitchen rear exit door to ensure proper closure. Replace the recommended fly light bulbs and starters - Report dated 07/09/26 reflected, in part, [Vendor Name] completed a specialized fly control service targeting house flies, drain flies. fly wipe-down treatments were performed on common resting areas. bulbs were replaced in the kitchen light unit. Record review of the facility's Pest Control Program policy, dated 1/10/2020, reflected .It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents. 4. Facility will utilize a variety of methods in controlling certain seasonal pests, i.e. flies. These will involve indoor and outdoor methods that are deemed appropriate by the outside pest service and state and federal regulations.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 (Resident #10) of 5 residents reviewed for comprehensive care plans. The facility failed to update Resident #10's care plan to address the use of a smoking apparatus. The facility failed to ensure Resident #10 was wearing an apron as it was on the ground underneath table where CNA C was standing. This failure could result in the resident not receiving appropriate supervision, protection and care during smoking breaks. Findings included: Review of Resident #10's MDS dated [DATE] indicated Resident #10 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #10 had a diagnoses that included stroke (sudden interruption of blood flow to the brain), Non-Alzheimer's Dementia (conditions that impair memory, cognition, and daily functioning), Parkinson's Disease (affects movement, balance, tremors), Anxiety Disorder (excessive, uncontrollable worry about everyday issues, affecting daily function and quality of life), Bipolar Disorder (elevated mood, increased energy, and decreased need for sleep, while depressive episodes can lead to feelings of sadness, hopelessness, and loss of interest in activities), Psychotic Disorder (state of having difficulty distinguishing what is real from what is not), Post Traumatic Stress Disorder (intrusive thoughts, avoidance behaviors, negative changes in mood and cognition), and Chronic Obstructive Pulmonary Disease (progressive lung disease that makes it difficult to breathe, primarily caused by long-term exposure to irritants like cigarettes smoke and air pollution), and muscle weakness. Review of Resident #10's undated care plan revealed: [Resident #10] is a smoker and is at risk for injury. Dependent Smoker. [Resident #10] is a dependent smoker and required staff supervision to reduce the risk for smoking related injuries. Goal: [Resident #10] will abide by facility's smoking policy and remain safe during times. Interventions included assist resident to and from smoking area as needed. Perform smoking assessment according to facility policy. Remind family of need for smoking apron for unsafe smoker and that they must remain with the resident when smoking to prevent injury. Residents use a smoking apron during smoke breaks. Staff to provide direct supervision to unsafe smokers. Resident #10's care plan did not express the use or requirement of a smoking apparatus. Resident #10 did not have a smoking assessment in her clinical records. Observation and interview on 07/29/26 at 3:40 PM with Resident #10 revealed her outside during a smoking break with an apron across the front of her body. Resident #10 had a tubing device, with one end of the tube in her hand to administer to her mouth and the other end connected to a lit cigarette. The cigarette was observed to drop ashes to an ashtray that was connected to her wheelchair. According to Resident #10 she was required to use the apron and tube (smoking apparatus) if she wanted to smoke. Resident #10 expressed staff assisted her to the smoking patio, provided an apron and the smoking apparatus during each smoking break. Observation and interview on 07/30/26 at 3:44 PM with CNA C revealed Resident #10 on the patio holding a smoking apparatus in her hand, administering it to her mouth for smoking. Resident #10 was not wearing an apron as it was on the ground underneath table where CNA C was standing. According to CNA C, Resident #10 was a smoker, she required supervision, which included the smoking tube and ashtray that was connected to her wheelchair. CNA C stated Resident #10 did not have to use the apron because she used the smoking apparatus. CNA C explained both the smoking (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	apparatus and the apron were used to provide protection against Resident #10 burning herself or clothing if she was to drop her cigarette. CNA C stated she had training to supervise residents during smoking breaks which included which residents required supervision. CNA C stated staff who took residents out to smoke were responsible for supervising residents and administering any protective equipment. CNA C stated not properly supervising residents placed them at risk of burn injuries. Interview on 07/30/2026 at 6:35 PM with the DON revealed all staff that assisted residents with smoking were aware that Resident #10 required protective equipment. The DON stated Resident #10 now used a smoking apparatus, which did not require the use of an apron. The DON did not indicate when Resident #10 started using the smoking apparatus. The DON further expressed all staff were responsible for ensuring resident care plans were updated. The DON stated Resident #10's use of the smoking apparatus should have been included in her care plan so that all staff knew how to properly assist her during smoking breaks. Review of facility policy Comprehensive Care Plans dated: 02/10/21 reflected the following: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessments. The comprehensive care plan will describe, at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** Based on observation, interview, and record review, the facility failed to ensure that residents receiving enteral feeding received appropriate care and services to prevent complication of enteral feeding for 1 of 3 residents (Resident #6) reviewed for enteral feeding. The facility failed to ensure LVN F checked G-tube (tube placed into the stomach to deliver food, liquids, and medicine) placement prior to administering Resident #6's medications on 07/29/26 per facility policy and physician's order. These failures could place residents at increased risk of aspiration, bloating discomfort, and not receiving the full benefit of the medications administered. Findings included: Record review of Resident #6's Face Sheet, dated 07/30/26, reflected a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #6's Significant Change MDS, dated [DATE], reflected that he had the following diagnoses: Encephalopathy (any disease, damage, or malfunction of the brain that causes altered mental function), Dysphagia (difficulty swallowing), and Malnutrition. The MDS also reflected Resident #6's cognitive skills were severely impaired, and he required a feeding tube for nutrition. Record review of Resident #6's Care Plan, undated, reflected that he required the use of a feeding tube for all nutrition with an intervention to check for tube placement per facility protocol. Record[BR57.1] review of Resident #6's order summary reflected the following: Enteral Feed Order every shift for monitor check G/T placement before administration of meds and enteral feedings. Enteral Feed Order every shift. Flush enteral tube with 30ml water pre/post medication administration and 5-10 ml water between each medication Observation on 07/29/26 at 7:34 AM reflected LVN F performed hand hygiene, and prepared the following medications into one medication cup: Vitamin D3 1000-unit 1 capsule Acetaminophen 500 mg 1 tablet Ascorbic Acid 250 mg (Vitamin C) 2 tablets Zinc Sulfate 220 mg 1 tablet Thiamine 100 mg 1 tablet Eliquis 5 mg (blood thinner) 1 tablet Tizanidine 4 mg (muscle relaxer) 1 tablet Atorvastatin 40 mg 1 tablet LVN F also prepared medication multivitamin with minerals 5 ml of liquid and Prostat 30 ml (wound healing supplement) in separate medication cups. LVN F crushed the medication tablets together and poured the crushed medications into a new cup. LVN F then mixed the medications with water. After preparing the medications, LVN F performed hand hygiene, applied PPE, and entered Resident #6's room. The medications were set on a clean table with a barrier. LVN F paused and disconnected Resident #6's tube feeding. LVN F connected the syringe to the G-tube and flushed[BR58.1] with 30 ml of water via gravity, poured the crushed medications into the syringe[BR59.1], flushed with 10 ml of water, administered the Prostat, flushed with 10 ml of water, administered the multivitamin, and then flushed with 30 ml of water all via gravity. LVN F then restarted the tube feeding, discarded the supplies, removed the PPE and washed his hands before exiting the room. LVN F did not check G-tube placement before administering the medications and did not administer the medication tablets separately. Interview on 07/29/26 at 8:05 AM with LVN F revealed he had worked at the facility for 2 years. He stated he had been trained on G-tube administration, but he was nervous. LVN F stated he forgot to check the tube placement and pointed to his stethoscope on the medication cart. He stated the risk of not checking the placement was administering the medication in the wrong place if the tube was dislodged. Interview on 07/30/26 at 4:21 PM with ADON A revealed that she expected the nurses to crush each medication separately, check placement with auscultation (listening with a stethoscope while pushing a small amount of air into the g-tube), and follow the physician's orders with flushing in-between the medications. ADON A stated the nurses were responsible for ensuring (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the proper administration of medication. ADON A stated checking the tube placement was important to ensure it was in the proper position. She stated the risk of not checking G-tube placement was administering in the incorrect placement and causing harm to the resident. Interview on 07/30/26 at 5:46 PM with the DON revealed that she expected the nurses to check placement before administering any medications. She stated that was important to ensure it was in the proper place. The DON stated the risk of not checking placement was administering medications in the wrong area. The DON stated the risk of mixing medications was drug interactions. Record review of the facility policy, titled Enteral Tube Feeding revised 02/22/25, reflected the following: .7. Each medication is prepared individually so that it can be administered separately.9. Enteral tube placement must be checked via auscultation and/or aspiration (attach a syringe and draw out a small amount of stomach fluid] before any fluids or medication is administered.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals for 2 of 6 residents (Resident #60 & #76) and 1 of 3 medication carts (Station 2 Nurse cart) reviewed for pharmaceutical services. 1. MA E failed to supervise Resident #60 after she left the resident's medications in his room during morning medication administration on 07/28/26. 2. The facility failed to ensure that one bottle of OTC Famotidine 10 mg, with an expiration date of January 2026, and a bubble pack of Ondansetron 8 mg tablets prescribed to Resident #76, with an expiration date of 06/20/26, had been removed from the Station 2 nurse cart. This failure could place the residents at risk of not receiving medications as ordered by the physician or receiving medications that were ineffective. Findings included: 1. Record review of Resident #60's Face Sheet, dated 07/29/26, reflected a [AGE] year-old male who admitted on [DATE]. Record review of Resident #60's Quarterly MDS, dated [DATE], reflected he had the following diagnoses: Diffuse Traumatic brain Injury with loss of consciousness (Widespread damage to brain's nerve fibers), Hypertension (high blood pressure), and need for assistance with personal care. The MDS also reflected Resident #60 had a BIMS score of 15, indicating he was cognitively intact. Record review of Resident #60's Care Plan, undated, reflected the resident was taking a black box medication (high-risk medication) and had cognitive impairment with an intervention to administer medications per physician's orders and monitor for effectiveness or adverse reactions. Record review of Resident #60's Self Administration Evaluation Assessment, dated 07/21/21, reflected he was unable to safely administer medications. Record review of Resident #60's July MAR and physician orders reflected the following medications were administered the morning of 07/28/26 by MA E: Amiodarone 200 mg tablet (medication used to treat and prevent life-threatening heart rhythm problems) Aspirin 81 mg tablet Cholecalciferol 50 mcg tablet (Vitamin D) Cranberry 450 mg tablet Folic Acid 1 mg tablet Multivitamin tablet Thiamine 100 mg tablet Tylenol 325 mg 2 tablets Zoloft 50 mg tablet for depression Gabapentin 300 mg capsule for neuropathy Interview and observation on 07/28/26 at 10:59 AM with Resident #60 reflected he was lying in bed. Medications in cup observed on bedside table in front of him. Resident #60 stated he was going to take his medications right now, that he just needed to open his coca cola first. No staff member was present in the room. Observation reflected at least 6 medications in the cup, with 1 red tablet. Resident #60 decline to allow the medications to be counted. He stated he did not want [VT70.1] anything written down about the medications or for the staff to get in trouble. Resident #60 stated the staff member just dropped off his medications a couple minutes ago and would not say the staff's name. Resident #60 stated he had a lot of medications and preferred to take them by himself, so he asked the staff member to leave them. He stated the staff would not always leave the medications on his table, but he preferred when they did. During the interview, Resident #60 took his medications. Interview on 07/28/26 at 11:23 AM, LVN H stated MA E gave Resident #60 his medications that morning. Interview on 07/28/26 at 12:23 PM with MA E reflected that she gave morning medications to Resident #60. She stated she did leave the medications on his table and did not observe him taking the medications. MA E stated that Resident #60 told her to leave the medications and leave the room. She stated Resident #60 would not take the medications if she watched him and that she would wait all day. MA E stated the nurses were aware that Resident #60 had that behavior. She stated she was not supposed to leave medications at the bedside because (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there was a risk another resident could take them instead. MA E stated she would go back to ensure that he took his medications by seeing the empty medication cup. MA E stated she had been trained to not leave the medications at the bedside. Interview on 07/30/26 at 1:07 PM with LVN H reflected that she was the nurse for Resident #60. LVN H stated the MAs should always watch Resident #60 take the medications and not leave them unattended. She stated it was protocol to ensure that the residents took the medications. LVN H stated the MAs were responsible for ensuring that they were administering the medications. LVN H stated the risk of leaving medications unattended was the resident may not take them and it could harm the resident. Interview on 07/30/26 at 5:02 PM with ADON B reflected that she expected the staff to watch all the residents take the medications. ADON B stated the nurses and MAs were responsible for ensuring the residents were taking the medications. ADON B stated she was not aware of medications being left in Resident #60's room unattended. She stated Resident #60 could be difficult, but that medications should not be left unattended. ADON B stated the risk of leaving medications unattended was another resident could take the medications or the resident may not take them and cause side effects. Interview on 07/30/26 at 5:46 PM with the DON reflected that she expected her staff to observe the residents taking their medications. She stated if the resident does not want to take the medications, then the medications should be taken out of the room. The DON stated the nurses were responsible for ensuring that the medications were administered. The DON stated Resident #60 could not self-administer medications. The DON stated the risk of leaving medications unattended was another resident could potentially take the medications. 2. Record review of Resident #76's Face Sheet, dated 07/30/26, reflected a [AGE] year-old male who admitted on [DATE] and readmitted on [DATE]. Record review of Resident #76's Quarterly MDS, dated [DATE], reflected he had the following diagnoses: Dementia (decline in brain function that interferes with daily life) and Nausea with vomiting. The MDS also reflected Resident #76's cognitive skills were moderately impaired. Record review of Resident #76's Care Plan, undated, reflected that he had cognitive impairment related to his Dementia and to administer medications per physician's order. The care plan also reflected that the resident received medications and to monitor for any nausea or vomiting. Record review of Resident #76's order summary, dated 07/30/26, reflected: Ondansetron (Zofran) 8 mg tablet give 1 tablet every 12 hours as needed for nausea and vomiting. Record review of Resident #76's MAR from 06/20/2026-07/29/26 reflected that he did not receive any as needed doses of Ondansetron. Observation on 07/29/26 at 12:02 PM of the Station 2 Nurse hallway medication cart with LVN H reflected a bubble pack of Ondansetron 8 mg prescribed to Resident #76 with 2 tablets remaining that had expired on 06/20/26. Observation also revealed OTC Famotidine (medication to reduce stomach acid) 10 mg with an expiration date of 01/2026. Interview on 07/29/26 at 12:05 PM with LVN H, she stated the Famotidine expired in January 2026 and the Ondansetron expired on 06/20/26. She stated she had not given the Ondansetron to Resident #76 in a while and was not able to recall the last dose given. LVN H stated she checked her medication cart for expired medications when she had time and before administering the medications. LVN H stated the nurses were responsible for ensuring there were no expired medications on the carts. She stated the risk of having expired medications was they could be administered and cause an adverse reaction. Interview on 07/30/26 at 5:02 PM with ADON B, she stated that she expected the nurses to check the expiration date before administering medications. She stated she would check the medication carts quarterly and as needed to ensure there were no expired medications. ADON B was unable to recall the last time she reviewed the medication carts. ADON B stated the nurses were responsible for ensuring there were no expired medications in their carts. She stated the risk of having expired medications in the cart was they could be given and cause side effects or be ineffective. Interview on (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/30/26 at 5:52 PM with the DON reflected that she expected her staff to check for expired medications when administering any medications. She stated they had pharmacy that came once a month and the ADONs did random audits to ensure there were no expired medications. The DON stated the nurses were responsible for ensuring there were no expired medications. She stated the risk of having expired medications was they could be administered to the residents and not be effective. Record review of the facility's Medication Administration: Medication Pass policy, revised 02/10/20 reflected the following: .Remain with patient until administration of medications is complete.Record review of the facility's Medication Storage Policy, dated 01/20/21 reflected the following: .8. Medication Carts are routinely inspected for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are removed and destroyed in accordance with the facility policyVT.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** Based on observation, interview and record review the facility failed to ensure the medication error rate was not five percent (5%) or greater. The facility had a medication error rate of 27.59%, based on 8 errors out of 29 opportunities, which involved 1 of 5 residents (Resident #6) and 1 of 3 staff (LVN F) observed during medication administration reviewed for medication error. The facility failed to ensure LVN F mixed each crushed medication with water and administered one medication at a time through Resident #6's g-tube. This failure could place residents at risk of medication interactions leading to an altered therapeutic response. Findings include: Record review of Resident #6's Face Sheet, dated 07/30/26, reflected a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #6's Significant Change MDS, dated [DATE], reflected that he had the following diagnoses: Encephalopathy (any disease, damage, or malfunction of the brain that causes altered mental function), Dysphagia (difficulty swallowing), and Malnutrition. The MDS also reflected Resident #6's cognitive skills were severely impaired, and he required a feeding tube for nutrition. Record review of Resident #6's Care Plan, undated, reflected that he required the use of a feeding tube for all nutrition with an intervention to check for tube placement per facility protocol. Record review of Resident #6's order summary reflected no physician order to combine medication tablets or cocktail medications. Observation on 07/29/26 at 7:34 AM reflected LVN F performed hand hygiene, and prepared the following medications into one medication cup: Vitamin D3 1000-unit 1 capsule Acetaminophen 500 mg 1 tablet Ascorbic Acid 250 mg (Vitamin C) 2 tablets Zinc Sulfate 220 mg 1 tablet Thiamine 100 mg 1 tablet Eliquis 5 mg (blood thinner) 1 tablet Tizanidine 4 mg (muscle relaxer) 1 tablet Atorvastatin 40 mg 1 tablet LVN F also prepared multivitamin with minerals 5 ml of liquid and Prostat 30 ml (wound healing supplement) in separate medication cups. LVN F crushed the medication tablets together and poured the crushed medications into a new cup. LVN F then mixed the medications with water. After preparing the medications, LVN F performed hand hygiene, applied PPE, and entered Resident #6's room. The medications were set on a clean table with a barrier. LVN F paused and disconnected Resident #6's tube feeding. LVN F flushed with 30 ml of water via gravity, poured crushed medications into syringe, flushed with 10 ml of water, administered the prostat, flushed with 10 ml of water, administered the multivitamin, and then flushed with 30 ml of water all via gravity. LVN F then restarted the tube feeding, discarded supplies, removed PPE and washed his hands before exiting the room. LVN F did not administer the medication tablets separately. Interview on 07/29/26 at 8:05 AM with LVN F reflected he had worked at the facility for 2 years. LVN F stated he typically crushed the medication tablets together if they were not enteric coated (outer layer on pills and capsules that stops them from dissolving in the stomach). He stated he was aware that he was not supposed to mix the liquids but thought if the tablets were not enteric coated, they could be given together. LVN F stated administering the medications together could put a risk of medication interaction and cause an adverse reaction to the resident. He stated he had been trained on G-tube administration, but he was nervous. Interview on 07/30/26 at 4:21 PM with ADON A reflected that she expected the nurses to crush each medication separately, check placement with auscultation, and follow the physician orders with flushing in-between the medications. ADON A stated the medications should not be crushed together. She stated there was a risk of potential interactions and side effects of the medications if they were crushed and administered together. ADON A stated the nurses were responsible for ensuring the proper administration of medication. Interview on 07/30/26 at 5:46 PM with the DON reflected that she expected her staff to crush and administer medications for G-tube (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER White Settlement Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration separately. She stated the medications should not be cocktailed. The DON stated the risk of mixing medications was drug interactions. The DON stated it was a medication error to mix the medications together. The DON stated it was the nursing team's responsibility to ensure proper medication administration. Record review of the facility policy, titled Enteral Tube Feeding revised 02/22/25, reflected the following: .7. Each medication is prepared individually so that it can be administered separately.9. Enteral tube placement must be checked via auscultation and/or aspiration before any fluids or medication is administered. Record review of the facility policy, titled Prevention of Medication Errors revised 02/10/22, reflected the following: Medication error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order, manufacturer's specification or accepted professional standards and principals.25. Crushed meds are combined only as indicated based on person centered.		