

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675969	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER Settlers Ridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1280 Settlers Ridge Rd Celina, TX 75009	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971</p> <p>Based on observations, interviews, and record review the facility failed to provide the necessary services for residents who were unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 (Resident#1) of 6 residents reviewed for ADLs.</p> <p>The facility failed to ensure Resident #1 had his fingernails cleaned and trimmed.</p> <p>This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections, and a decreased quality of life.</p> <p>Findings included:</p> <p>Review of Resident #1's Quarterly MDS assessment dated [DATE] reflected Resident #1 was an [AGE] year-old male with initial admitted to the facility on [DATE]. His diagnoses included fracture of part of neck of left femur (the bone of the thigh), Obstructive uropathy (urine cannot drain through the urinary tract), and Alzheimer's disease. Resident #1 had a BIMS of 99 which indicated Resident #1 was unable to complete brief interview for mental status. Resident #1 required moderate assistance with personal hygiene.</p> <p>Review of Resident #1's Comprehensive Care Plan, revised 07/04/24, reflected the following: Care area: Self-Care Deficit Goal: [Resident #1] Will maintain or improve self-care area of dressing, grooming hygiene and bathing Interventions: . Provide assistance with self-care as needed.</p> <p>An observation on 11/19/24 at 09:47 AM, revealed Resident #1 was laying in his bed. The nails on both hands were approximately 0.3 centimeters in length extending from the tip of his fingers and had black substance underneath the nails and around the nail beds. Resident #1 was unable to answer questions.</p> <p>In an interview on 01/19/24 at 11:00 AM, with CNA A revealed she was assigned to Resident #1. She stated that most ADL's such as hair trimming, nail clipping was completed during shower times. She revealed that since Resident #1 was not a Diabetic resident, CNAs were responsible for clipping and cleaning his nails. CNA A stated that fingernail clipping should be done weekly or as needed and the risk of not cleaning/trimming fingernails could be increased risk of infection. CNA A stated she did not check Resident #1's nails this morning when she changed him.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with the DON on 11/20/24 at 12:59 PM, revealed her expectation was that nail care should be provided as needed, especially during shower time. She stated that CNAs were responsible for doing nail care unless the resident had a diagnosis of diabetes. She also stated that as the DON, either herself or her designee were responsible to do routine rounds for monitoring. The DON stated that residents having long, and dirty fingernails could be an infection control issue and skin breakdown.</p> <p>Record review of the facility policy titled Bathing revised 02/12/20 reflected: . Perform hand hygiene and perform nail care</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one (Resident #2) of one resident reviewed for catheter care.</p> <p>The facility failed to ensure LVN B maintained Resident #2's indwelling urinary catheter drainage bag below the bladder level during wound care on 11/19/24.</p> <p>This failure placed residents at risk for not receiving care appropriate to address their incontinence and risk for infection.</p> <p>Findings included:</p> <p>A record review of Resident #2's Quarterly MDS assessment dated [DATE] reflected Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included multiple sclerosis (a disease resulting in nerve damage), stage 4 pressure ulcer, and neuromuscular dysfunction of bladder (the nerves and muscles of the bladder don't communicate properly with the brain, resulting in bladder control issues). Resident #2 had a BIMS of 12 which indicated Resident #2's cognition was moderately impaired. She required extensive assistance of two-person physical assistance with bed mobility. MDS assessment, section bowel and bladder reflected resident had an indwelling urinary catheter.</p> <p>Record review of Resident #2's care plan revised on 01/25/24 reflected, Urinary catheter . Resident will be free of complications of indwelling catheter . Goal: Resident will be free of complication of indwelling catheter . Interventions: Care/changing of urinary catheter as ordered .</p> <p>Review of Resident #2's Order Summary report dated November 2024, reflected, Foley Catheter (indwelling urinary catheter) every shift to continuous gravity drainage and catheter care. with a start date of 06/19/24.</p> <p>Observation on 11/19/24 at 11:32 AM, revealed LVN B entered Resident #2's room to do wound treatment. CNA C entered Resident #2's room to assist LVN B. Both staff washed hands, donned gowns and gloves. LVN B unhooked the urinary catheter bag from the bed rail and put it flat on the foot of bed, above the resident's bladder. LVN B provided wound care to the sacrum wound. During the procedure urine was observed flowing back toward the resident's bladder. LVN B finished the treatment and then she hooked the urinary catheter bag onto the bed rail. Observation of the urinary catheter bag revealed approximately 300 milliliters of urine in the bag.</p> <p>In an interview with LVN B on 11/19/24 at 11:49 AM, she stated that the urinary catheter bag tubing was short and to prevent pulling on the catheter tubing she put the catheter bag on the bed. She stated the catheter bag and catheter tubing were supposed to be kept below the bladder. She stated failing to do this could cause the urine to back up and might cause an infection. She stated she supposed to empty the catheter bag before putting it on the bed.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the DON on 11/20/24 at 12:59 PM, she stated any resident with an indwelling urinary catheter should always have the catheter bag and catheter tubing below the bladder. She stated not keeping the urinary catheter bag below the resident's bladder, placed them at risk of urinary tract infection. She stated to ensure staff were knowledgeable in the care of indwelling catheter the facility does skills competency checks. She stated when staff needed to be re-trained, she provided the in-service training.</p> <p>Record review of LVN B's competency check off for catheter care revealed she was proficient in care as of 11/20/24. No other training was provided.</p> <p>Review of the facility's policy titled, Urinary Catheter Infection Prevention reviewed January 2022 reflected, . 8. Gravity drainage bags are positioned below the level of the patient's bladder .</p>