STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675969	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Settlers Ridge Care Center	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to immediately inform the resident, consult with the resident's physician, notify, consistent with his or her authority, the resident representative when there was a significant change in the resident's physical, mental, or psychosocial status for 1 of 4 resident (Resident #1) reviewed for notification of changes. The facility failed to notify Resident #1's physician when an injury of unknown origin was discovered on 5/06/2025. This deficient practice could place residents at risk of not having their physician informed when there was a change in condition resulting in a delay in medical intervention and decline in health. Findings include: Record review of Resident #1's Face Sheet revealed that the resident was a [AGE] year-old female. She was admitted to the facility on [DATE] and discharged on 5/06/2025. She was a respite care (temporary care services) resident. Diagnoses of Alzheimer's disease (brain condition that progressively damages memory, thinking, and learning skills), Hyperlipidemia (High cholesterol), Dysphagia (Difficulty swallowing), Protein-calorie malnutrition, Anxiety disorder (Mental health conditions characterized by excessive fear, dread, or apprehension that arises without a clear or appropriate cause), History of falling, Dementia (Loss of cognitive function), Adult failure to thrive (Substantial decline in overall health and functional abilities), Parkinson's disease with dyskinesia (Dyskinesia is a term used to describe involuntary, uncontrollable movements), and Pain. Record review of Resident #1's Care Plan revealed that Resident #1 had a fall on 5/03/2025. Goals include that Resident #1 will be free from complications related to falling over the next 3 days and resident at risk for falls resident safety will be maintained over the next 90 days. Resident fall interventions include assess contributing factors related to fall history, assess for potential fall-related injury prevention, looking at circumstances, location, medication, new or worsening medical problems, etc., Keep call light and most frequently used personal items within reach, remind resident to call when needing assistance. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's electronic medical records reflected Resident #1 had a progress note on 5/03/2025 at 4:51 PM that was entered by LVN B. The progress note referenced the assessment for Resident #1 and stated that Resident #1 had fallen asleep in her chair slouched over. LVN B repositioned Resident #1 attempting to prevent a fall. Approximately 30 minutes later, CNA C alerted LVN B that Resident #1 had repositioned herself. Resident #1 had fallen back asleep and slouched over causing Resident #1 to fall out of her chair. Resident #1 was assessed with no noticeable injuries. Resident #1 denied pain. Record review of Resident #1's MDS Assessment, dated 5/05/2025, reflected Resident #1 had a BIMS (Brief Interview for Mental Status Test) score of 2 (Severe Cognitive Impairment). Resident #1 was assessed to require assistance with ADLs including the following: transfers, personal hygiene, showers, and dressing. Record review of the facilities Activities of Daily Living care log on 6/18/2025, dated 5/06/2025, reflected that CNA provided ADL care to Resident #1 at 7:51 PM. No injuries or change in condition were noticed at that time. Record review of Resident #1's electronic medical records reflected Resident #1 had a progress note on 5/06/2025 at 10:56 PM that was entered by LVN A. The progress note stated that there was a concern made by the family about the resident's care and the family requested to speak with the Director of Nursing. Record review of LVN A's employee statement, not dated, reflected that LVN A was working the night shift on 5/06/2025 when Resident #1 was discharged at 10:56 PM. The resident was discharged because it was the end of her Respite Care. He stated that the family member had concerns about Resident #1's care because there was some bruising that the family was not aware of. He stated that he saw the bruising on Resident #1's face but there was no open wound. He stated Resident #1 was in her wheelchair with her head facing down and not able to voice what happened. Record review of TULIP (Texas Unified Licensure Information Portal) on 6/18/2025 revealed that the facility did not report the injury of unknown origin for the wound that was discovered on 5/06/2025. The facility failed to follow the requirements by not reporting the incident within 24 hours of discovering the incident. Observation of video submitted by Family Member X dated 5/07/2025 at 1:10 pm in Resident #1's room at the nursing facility revealed an injury located on the right side of Resident #1's cheek. The injury appeared as a linear abrasion that was deeper than a scratch. The skin where the injury was located was bright red, clotted, and an irregular shape about 2.5 centimeters in diameter which Physician D claimed was caused by blunt force trauma. Timestamp date is inconsistent with the time of Resident #1's discharge time and date. Observation of photograph submitted by Family Member X dated 5/07/2025 at 1:10 pm in Resident #1's room at the nursing facility revealed Resident #1's injury to the right side of her cheek. The injury appeared as a linear abrasion that was deeper than a scratch. The skin where the injury was located was bright red, clotted, and an irregular shape about 2.5 centimeters in diameter which Physician D claimed was caused by blunt force trauma. Timestamp date is inconsistent with the time of Resident #1's discharge time and date. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Physician D on 6/18/2025 at 9:00 AM confirmed that the wound appeared to be open and recent to the time of the photograph. Interview with Wound Care Nurse H on 6/17/2025 at 2:10 PM revealed that the wound appeared to be open and recent to the time of the photograph. Interview on 6/17/2025 at 9:40 AM with Director of Nursing F revealed that staff are trained to notify the administrator, director of nursing, physician, and responsible party if they find a wound or injury of unknown origin. She stated the reason this wound was not reported was because it was not something that they thought was a new injury because it was assumed to be related to the fall incident that occurred on 5/03/2025. Director of Nursing F stated that the physician and family members were notified of the fall that occurred on 5/03/2025. It was a witnessed fall. Director of Nursing F stated that she had seen Resident #1 on 5/06/2025 during the day shift and the wound was not there at that time. She stated that she did not know that when the family called to complain about Resident #1's injury that they were talking about that specific injury that she was not aware of. She stated that she assumed that Resident #1's family were calling to complain about a bruise on the right side of Resident #1's face that was related to the fall that occurred on 5/03/2025. Interview on 6/17/2025 at 11:00 AM with RN I, revealed that he saw Resident #1 on 5/06/2025. and saw that she had a bruise on the right side of her face above her eye. He stated it was a light purple bruise but there was no open skin. He stated the wound did not have any open areas and that it was right above her eye. Interview on 6/18/2025 at 9:00 AM with Physician D revealed the facility did not notify her of the wound in the video and photograph that was discovered on 5/06/2025 at 10:56 PM. She stated that she was at the facility on 5/06/2025 and observed Resident #1 around 9:00 AM. She stated Resident #1 did not have the injury that can be seen in the video and photographs when she observed her. She stated that the injury had to of happened after she left the facility that day. She stated that the wound appeared to be open and would have met the criteria for someone who should have been seen by the wound care nurse. She stated that had she seen that wound she would have provided wound care by applying ointment and bandaging the wound. She stated that the wound was not significant but that it should still have been treated. She stated that the wound looked like it was caused by blunt trauma possibly from her slouching over in her wheelchair and hitting the wheelchair armrest. She stated that the resident slouches over in her chair a lot and she could have hit her face on her armrest. She stated that she remembered being notified by LVN B of Resident #1 having the fall on 5/03/2025. She stated that she did not think that the fall and the injury to her cheek are related and that they had to of occurred at separate times. She stated that she should be contacted about any new injury of unknown origin, open wound, or injury. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Settlers Ridge Care Center	1280 Settlers Ridge Rd Celina, TX 75009

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/18/2025 at 10:00 AM with Administrator J, revealed that he had spoken to RN I and learned that Resident #1 had light bruising on 6/05/2025. He stated that RN I knew about Resident #1's fall on 5/03/2025 and thought that the bruising was related to the fall. Administrator J stated that all the staff were inserviced on 6/17/2025 on documentation and notifications. Administrator J stated that he had talked to LVN A and learned that the injury was there at the time of discharge on [DATE] at 10:56 PM. He stated that LVN A had talked to the family, and they wanted to know what happened to Resident #1's face. Administrator J stated that everyone that was communicating with the family was communicating with them under the assumption that they were all talking about the injury that was related to the fall that occurred on 5/03/2025 and not about the injury of unknown origin that was discovered on 5/06/2025. He stated that they were communicating with inaccurate information that they didn't know was inaccurate because of the circumstances of the fall occurring a few days prior. Administrator J stated that the staff didn't notice that this was a new injury to Resident #1's face and assumed it was from the fall. He stated that it was unfortunate but that's just what happened. He stated the staff were inserviced to go back and check or compare notes to make sure that they are consistent with any injuries that are discovered. Interview on 6/18/2025 at 10:30 AM with RN I, revealed that the wound to Resident #1's cheek in the photograph and video were not there when he saw the resident during the day shift around 3:00 PM on 5/06/2025. He stated that if there had been an open wound then he would have provided wound care immediately and documented it. He stated if there had been a new wound then he would have notified the family and physician. LVN A was attempted to be interviewed on 6/18/2025 at 1:08 PM. Message was left requesting a call back. Record Review of the Facility Abuse & Neglect Policy dated June 23, 2017, reviewed February 12, 2020, states that The purpose of this policy is to ensure that all healthcare facilities comply with federal and state regulations regarding (i) protecting facility patients and residents from abuse, neglect, exploitation and misappropriation of resident property, and (ii) timely investigation of and reporting to state and local agencies all allegation of abuse, neglect, exploitation and misappropriation of resident property. All managed healthcare facilities and all management company staff members or third parties providing services to such facilities and/or their residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials, including to the State Survey Agency where state law provides for jurisdiction in long-term care facilities, in accordance with State law through established procedures for 1 of 4 residents (Resident #1) reviewed for reporting. The facility failed to report an injury of unknown origin that was discovered on 5/06/2025, to HHSC. This failure could place residents at risk for not having incidents reported as required. Findings included: Record review of Resident #1's Face Sheet revealed that the resident was a [AGE] year-old female. She was admitted to the facility on [DATE] and discharged on 5/06/2025. She was a respite care (temporary care services) resident. Diagnoses of Alzheimer's disease (brain condition that progressively damages memory, thinking, and learning skills), Hyperlipidemia (High cholesterol), Dysphagia (Difficulty swallowing), Protein-calorie malnutrition, Anxiety disorder (Mental health conditions characterized by excessive fear, dread, or apprehension that arises without a clear or appropriate cause), History of falling, Dementia (Loss of cognitive function), Adult failure to thrive (Substantial decline in overall health and functional abilities), Parkinson's disease with dyskinesia (Dyskinesia is a term used to describe involuntary, uncontrollable movements), and Pain. Record review of Resident #1's Care Plan revealed that Resident #1 had a fall on 5/03/2025. Goals include that Resident #1 will be free from complications related to falling over the next 3 days and resident at risk for falls resident safety will be maintained over the next 90 days. Resident fall interventions include assess contributing factors related to fall history, assess for potential fall-related injury prevention, looking at circumstances, location, medication, new or worsening medical problems, etc., Keep call light and most frequently used personal items within reach, remind resident to call when needing assistance. Record review of Resident #1's electronic medical records reflected Resident #1 had a progress note on 5/03/2025 at 4:51 PM that was entered by LVN B. The progress note referenced the assessment for Resident #1 and stated that Resident #1 had fallen asleep in her chair slouched over. LVN B repositioned Resident #1 attempting to prevent a fall. Approximately 30 minutes later, CNA C alerted LVN B that Resident #1 had repositioned herself. Resident #1 had fallen back asleep and slouched over causing Resident #1 to fall out of her chair. Resident #1 was assessed with no noticeable injuries. Resident #1 denied pain. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's MDS Assessment, dated 5/05/2025, reflected Resident #1 had a BIMS (Brief Interview for Mental Status Test) score of 2 (Severe Cognitive Impairment). Resident #1 was assessed to require assistance with ADLs including the following: transfers, personal hygiene, showers, and dressing. Record review of Resident #1's electronic medical records reflected Resident #1 had a progress note on 5/06/2025 at 10:56 PM that was entered by LVN A. The progress note stated that there was a concern made by the family about the resident's care and the family requested to speak with the Director of Nursing. Record review of LVN A's employee statement, not dated, reflected that LVN A was working the night shift on 5/06/2025 when Resident #1 was discharged at 10:56 PM. The resident was discharged because it was the end of her Respite Care. He stated that the family member had concerns about Resident #1's care because there was some bruising that the family was not aware of. He stated that he saw the bruising on Resident #1's face but there was no open wound. He stated Resident #1 was in her wheelchair with her head facing down and not able to voice what happened. Record review on 6/18/2025 of TULIP (Texas Unified Licensure Information Portal) revealed that the facility did not report the injury of unknown origin for the wound that was discovered on 5/06/2025. The facility failed to follow the requirements by not reporting the incident within 24 hours of discovering the incident. Observation of video submitted by Family Member X dated 5/07/2025 at 1:10 pm in Resident #1's room at the nursing facility revealed an injury located on the right side of Resident #1's cheek. The injury appeared as a linear abrasion that was deeper than a scratch. The skin where the injury was located was bright red, clotted, and an irregular shape about 2.5 centimeters in diameter which Physician D claimed was caused by blunt force trauma. Timestamp date is inconsistent with the time of Resident #1's discharge time and date. Observation of photograph submitted by Family Member X dated 5/07/2025 at 1:10 pm in Resident #1's room at the nursing facility revealed Resident #1's injury to the right side of her cheek. The injury appeared as a linear abrasion that was deeper than a scratch. The skin where the injury was located was bright red, clotted, and an irregular shape about 2.5 centimeters in diameter which Physician D claimed was caused by blunt force trauma. Timestamp date is inconsistent with the time of Resident #1's discharge time and date. Interview with Physician D on 6/18/2025 at 9:00 AM confirmed that the wound appeared to be open and recent to the time of the photograph. Interview with Wound Care Nurse H on 6/17/2025 at 2:10 PM revealed that the wound appeared to be open and recent to the time of the photograph. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/17/2025 at 9:40 AM with Director of Nursing F revealed that staff are trained to notify the administrator, director of nursing, physician, and responsible party if they find a wound or injury of unknown origin. She stated the reason this wound was not reported was because it was not something that they thought was a new injury because it was assumed to be related to the fall incident that occurred on 5/03/2025. Director of Nursing F stated that the physician and family members were notified of the fall that occurred on 5/03/2025. It was a witnessed fall. Director of Nursing F stated that she had seen Resident #1 on 5/06/2025 during the day shift and the wound was not there at that time. She stated that she did not know that when the family called to complain about Resident #1's injury that they were talking about that specific injury that she was not aware of. She stated that she assumed that Resident #1's family were calling to complain about a bruise on the right side of Resident #1's face that was related to the fall that occurred on 5/03/2025. Interview on 6/17/2025 at 10:30 AM with CNA C revealed that Resident #1 was seen falling to the ground in the dining room on 5/03/2025. CNA C alerted LVN B of the fall and LVN B assessed Resident #1. CNA C stated that Resident #1 did not have any signs of injury. CNA C stated that he never saw a wound on Resident #1's face while she was at the facility. Interview on 6/17/2025 at 11:00 AM with RN I, revealed that he saw Resident #1 on 5/06/2025. and saw that she had a bruise on the right side of her face above her eye. He stated it was a light purple bruise but there was no open skin. He stated the wound did not have any open areas and that it was right above her eye. Interview on 6/17/2025 at 2:10 PM with Wound Care Nurse H revealed that she saw a bruise on the upper right side of Resident #1's face over the weekend of Saturday 5/03/2025 and Sunday 5/04/2025. She stated that it was a light bruise on the upper right side of her face. She stated that she was never informed of any open wounds or skin tears. She stated that the wound in the video and photograph appeared to be an open wound with bleeding. She stated that it had to have occurred after she saw the resident on the weekend because it was not there when she saw that resident sitting in her chair over the weekend. She stated that she also does not believe that the resident would have gone 24, 48, or even 72 hours with a with a wound that was visibly bleeding on her face without being notified about it. Interview on 6/17/2025 at 2:20 PM with Assistant Director of Nursing G, revealed that he did see the bruise that was on Resident #1's upper right-hand side of her face on 5/06/2025 that was a result of her fall on 5/03/2025. He stated that there was no cut or skin tear when he saw her, and that Resident #1 was not bleeding. He stated that he never saw the a wound on Resident #1's cheek. He stated that if he had seen a wound on Resident #1 he would have notified the director of nursing, doctor, and family. He would have addressed it with the wound care nurse too. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/18/2025 at 9:00 AM with Physician D revealed the facility did not notify her of the wound in the video and photograph that was discovered on 5/06/2025 at 10:56 PM. She stated that she was at the facility on 5/06/2025 and observed Resident #1 around 9:00 AM. She stated Resident #1 did not have the injury that can be seen in the video and photographs when she observed her. She stated that the injury had to of happened after she left the facility that day. She stated that the wound appeared to be open and would have met the criteria for someone who should have been seen by the wound care nurse. She stated that had she seen that wound she would have provided wound care by applying ointment and bandaging the wound. She stated that the wound was not significant but that it should still have been treated. She stated that the wound looked like it was caused by blunt trauma possibly from her slouching over in her wheelchair and hitting the wheelchair armrest. She stated that the resident slouches over in her chair a lot and she could have hit her face on her armrest. She stated that she remembered being notified by LVN B of Resident #1 having the fall on 5/03/2025. She stated that she did not think that the fall and the injury to her cheek are related and that they had to of occurred at separate times. She stated that she should be contacted about any new injury of unknown origin, open wound, or injury. Interview on 6/18/2025 at 10:00 AM with Administrator J, revealed that he had spoken to RN I and learned that Resident #1 had light bruising on 6/05/2025. He stated that RN I knew about Resident #1's fall on 5/03/2025 and thought that the bruising was related to the fall. Administrator J stated that all the staff were inserviced on 6/17/2025 on documentation and notifications. Administrator J stated that he had talked to LVN A and learned that the injury was there at the time of discharge on [DATE] at 10:56 PM. He stated that LVN A had talked to the family, and they wanted to know what happened to Resident #1's face. Administrator J stated that everyone that was communicating with the family was communicating with them under the assumption that they were all talking about the injury that was related to the fall that occurred on 5/03/2025 and not about the injury of unknown origin that was discovered on 5/06/2025. He stated that they were communicating with inaccurate information that they didn't know was inaccurate because of the circumstances of the fall occurring a few days prior. Administrator J stated that the staff didn't notice that this was a new injury to Resident #1's face and assumed it was from the fall. He stated that it was unfortunate but that's just what happened. He stated the staff were inserviced to go back and check or compare notes to make sure that they are consistent with any injuries that are discovered. Interview on 6/18/2025 at 10:30 AM with RN I, revealed that the wound to Resident #1's cheek in the photograph and video were not there when he saw the resident during the day shift around 3:00 PM on 5/06/2025. He stated that if there had been an open wound then he would have provided wound care immediately and documented it. He stated if there had been a new wound then he would have notified the family and physician. LVN A was attempted to be interviewed on 6/18/2025 at 1:08 PM. Message was left requesting a call back. Record Review of the Facility Abuse & Neglect Reporting Policy dated June 23, 2017, reviewed February 12, 2020, states that: (ii) Timely investigation of and reporting to state and local agencies all allegations of abuse, neglect, exploitation, and misappropriation of resident property. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.2 All facility staff members have a duty to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to the Administrator of the facility, who serves as the Abuse Coordinator. In the Administrator's absence, the Director of Nursing (DON) or another designee will be appointed to function as the interim Abuse Coordinator. 3.3 Upon receiving an allegation abuse, neglect, exploitation or misappropriation, the Abuse Coordinator will a) notify the Regional Director of Operations and Regional Nurse Consultant, b) initiate an investigation into the allegation, c) in conjunction with the Region Director of Operations and Regional Nurse Consultant determine whether the allegation is reportable under federal and state regulations, and d) if the allegation is reportable, report such allegation to the State Regulatory Agency, Adult Protective Services (where state law provides jurisdiction in skilled nursing or assisted living facilities), and in certain cases, local law enforcement, within the following timeframes: A. Not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury; or B. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.