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	12/15/2025

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 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. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide a safe, clean, comfortable, and homelike environment for residents in 2 (Shower room [ROOM NUMBER] and Shower room [ROOM NUMBER]) of 5 shower rooms reviewed for environment. 1. The facility failed to properly clean and sanitize the floor, toilet and sink of Shower room [ROOM NUMBER] and failed to empty the trash and soiled linen bins. 2. The facility failed to properly clean and sanitize the floor of one of the showers in Shower room [ROOM NUMBER]. This failure could affect all residents that were showered in the shower rooms by exposing them to bacteria and organisms that could impact their health and diminish their quality of life. The findings include: Record review of a grievances filed on 10/27/25 revealed a resident relative requested a cleaner environment for their relative at the facility. During an observation of Shower room [ROOM NUMBER] on 12/15/25 at 9:55am revealed a strong odor of urine as upon entrance to the shower room. Against the wall were two large see-through bins with plastic bags. The first bin was overflowing with linen, and the top would not close. The second bin was labeled trash; it was closed and trash was full to the top. The toilet bowl was observed to have what looked like feces and urine in it. The floor had two dried red circular spots. The sink counter had a beige dirty shoe insole on the corner of it. During an observation of Shower room [ROOM NUMBER] on 12/15/25 at 10:06am revealed, one shower (the one straight ahead upon entrance to the room), had 5 various sized brown smudges that ranged from quarter size to pencil eraser size on the tiled floor of the shower. During an interview and observation with the Director of Environmental Services on 12/15/25 at 10:17am revealed housekeeping staff was responsible for cleaning the shower rooms once or twice a day and upon request. The Director of Environmental Services and surveyor entered Shower room [ROOM NUMBER] and observed the same 5 brown smudges on the shower floor of the first shower, the Director of Environmental Services stated she could not confirm what the smudges were. She stated housekeeping had not cleaned Shower room [ROOM NUMBER] yet, however the CNAs were responsible for cleaning the shower room after each use. The Director of Environmental Services then observed Shower room [ROOM NUMBER] with the surveyor and stated she could not say what the red drops on the floor were and no one had informed her there were red spots on the floor that needed cleaning. The Director of Environmental Services referred to the bins against the wall in Shower room [ROOM NUMBER] as the bed rolls and explained one side was soiled linens and one was trash. She stated the bed rolls were at the point they needed to be emptied because they were full and stated the strong urine odor in Shower room [ROOM NUMBER] could have been due to the bed rolls not being emptied. She stated the CNAs typically emptied the bed rolls several times per day. She reported Shower room [ROOM NUMBER] was typically cleaned after lunch and after dinner due to its high usage. The Director of Environmental Services reiterated it was the CNAs responsibility to clean the shower rooms after each shower throughout the day as needed. She stated the insole of the shoe observed in Shower room [ROOM NUMBER] should have been thrown away immediately and not left on the sink. The risk to the residents who were showered in a dirty shower was possible exposure to bacteria that could have made them sick. During an anonymous group interview with 8 Residents on 12/15/25 at 10:32am revealed the residents believed the shower rooms were messy and at times when they were taken to the shower rooms the shower rooms had dirty towels on the floor from the previous resident who showered. One of the anonymous residents stated they had observed feces on the floor in the shower on one occasion when staff took them to the shower room. During an interview with CNA A on 12/15/25 at 10:42 am revealed she was responsible for cleaning the showers after showering residents in the shower rooms. If a resident had an accident and there was urine or feces in the shower, she would have picked it up immediately and wiped the shower down. She would have then notified housekeeping about the need to sanitize the shower. CNA A stated the risk to the residents of not cleaning the showers after every use was the resident could have gotten sick, an infection or slipped if there was urine on the floor. During an interview with CNA B on 12/15/25 at 11:34 am revealed she had used the Shower room [ROOM NUMBER] about 8am and had not observed it to be dirty. CNA B stated it was the responsibility of the CNA to clean up any accidents that happened during or after a shower. She stated once they cleaned up any feces or urine, they would call housekeeping to sanitize the shower room. The risk of bringing a resident in the shower room while it was dirty with feces would have been the resident could have gotten contaminated or an infection. During an interview with CNA C on 12/15/25 at 11:44 am revealed she