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	02/20/2025

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690 Based on observation, interview, and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 1 resident (Resident #205) reviewed for intravenous fluids. RN A failed to change Resident #205's Central Venous Catheter line dressing using sterile technique. This failure could affect residents by placing them at risk for infections and cross-contamination. Findings include: Record review of Resident #205's Minimum Data Set Assessment, dated 02/11/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE], his BIMS score was 15/15 indicating intact cognition. His diagnoses included blood stream infection due to central venous catheter, respiratory failure, pneumonia (an infection that inflames the air sacs in one or both lungs). Record review of Resident #205's Order Summary Report, dated January 2023, reflected: PICC LINE (CVC) DRESSING CHANGE every 7 days 1 time per day, Dx: Bloodstream infection due to central venous catheter, subsequent encounter. An observation on 02/19/25 at 2:24 PM with Resident #205 revealed he was awake and lying on the bed. He had a PICC (CVC) line in his right upper chest with a dressing that has a one-inch tear on it. The line entry site was not red or swollen. RN A entered the resident's room with donned gown, clean gloves. She wiped the bed side table, let it to dry, and put the dressing change kit on it. RN A changed gloves performed hands hygiene, opened the sterile kit, got the mask from the kit and put it on the resident; RN A was wearing a mask as well. RN A removed gloves, sanitized hands, donned sterile gloves, and separated the sterile supplies individually for clear view. RN A put a white drape from the sterile kit underneath the line lumens without touching them, then removed the old dressing. RN A, without changing gloves, cleaned the line exit site with chlorhexidine, applied the Bio Patch, and clean dressing without using the skin prep on the sterile kit. RN A removed the white drape and proceeded to dispose of the rest of the sterile kit on the trash. When RN A was asked about the extra sterile gloves in the kit, she replied for a helper in case she needed another person to help her with the dressing change. (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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/19/25 at 2:47 PM with RN A, she stated supposed to change gloves with hands hygiene going from dirty to clean during the dressing change. RN A stated she received sterile dressing change training as an RN student at school two years ago, in the facility on hire two years ago, and annually. RN A stated the risk, if proper sterile technique was not followed, could be the development of infection for the residents. In an interview on 02/19/25 at 3:12 PM with the DON, she stated her expectation for the staff doing central venous/PICC line dressing change was to follow the proper sterile techniques, and to change gloves with hands hygiene going from dirty to clean tasks. The DON stated the nurse RNs received training with check list on the central venous line care on hire, and annually. The DON stated the risk, if proper sterile technique was not followed, could be the development of infection for the residents. Record review of RN A's annual skill check revealed it was done on 09/20/24. Record review of the facility's policy Titled Infusion Therapy Policy and Procedure Manual-2011 reflected: Midline, PICC and Central catheter dressing changes are performed using strict sterile technique . Removes and disposes of old dressing . Removes gloves and washes hands Sets up the sterile dressing tray .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 3 Residents (Resident #64) reviewed for respiratory care. 1. The facility failed to obtain an order for Resident #64's use of supplemental O2 with stated liter amount to be delivered. 2. The facility failed to include rationale for the use of O2 for Resident #64 from 02/16/25 through 02/18/25. These failures could place residents who received oxygen therapy at risk of receiving an incorrect amount of oxygen and the risk of oxygen toxicity. Findings Included: Record review of Resident #64's significant change MDS assessment dated [DATE], reflected an [AGE] year-old female with a re-entry date of 12/06/24 to the facility. She had a BIMS score of 9 which indicated her cognition was moderately impaired. Diagnoses included dementia, fractured hip, and coronary artery disease (damage or disease of the hearts major blood vessels). The resident required substantial to maximum assistance with ADL's. Resident #64 had not experience shortness of breath in the previous 5 days and had not received Oxygen therapy while a resident. Record review of Resident #64's care plan with an onset date of 02/15/25 reflected, Breathing patterns onset 02/15/25. Evidenced by Ipratropium 0.5 mg-albuterol 3 mg (used to open airways) .1 solution for Nebulization (converts liquid medication into a fine mist to be inhaled directly into the lungs) .Goal-Resident will demonstrate effective respiratory rate, depth, and pattern over the next 90 days .Interventions . Administer medications, respiratory treatments, and oxygen as ordered . Record of Resident #64's Physician orders report dated 02/20/25, reflected, Ipratropium 0.5 mg-albuterol 3 mg/3 ml nebulization-1 solution for nebulization inhalation every 6 hours with a start date of 02/17/25. There were no orders for oxygen therapy. Record review of Resident #64's Medication administration record dated February 2025 reflected, . ipratropium 0.5 mg-albuterol 3 mg (2.5 mg base)/3 mL nebulization. (IPRATROPIUM BROMIDE/ALBUTEROL SULFATE) 1 Solution for Nebulization Inhalation every 6 hours NEBULIZATION Dx: Nasal congestion Start Date:02/17/2025. Medication had been administered every 6 hours as ordered. There was no administration recorded for Oxygen therapy from 02/01/25 through 02/18/25. Record review of Resident #64's nurses notes dated 02/16/25 reflected: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05:15 a.m. Resident in bed resting comfortably resp. even and unlabored, crackle lung sound noted on auscultation, breathing treatment administrated as ordered with an effective result. 02 sats 94-96% on 02 @ 2L via NC Signed by LVN G 11:11 a.m. Resident lethargic, alert oriented x 1, sleeping comfortably, no s/sx of respiratory distress or any other discomfort noted, sating at 95% on 2l of oxygen .[NP] On call notified. IV hydration completed. Received orders for midline (IV access) insertion x1, normal saline 0.9% IV X 2 liters, CEFTRIAXONE (antibiotic) 1 GRAM Q 24HRS X 3 DAYS, vital signs q 6 hours x 48 hours Family notified Singed by LVN F. In an observation on 02/18/25 at 10:05 a.m., Resident #64 was observed in bed with O2 via nasal cannula. The O2 concentrator was set to deliver 2 liters per minute. In an interview on 02/20/25 at 11:30 a.m. with LVN F, she stated Resident #64 was having difficulty breathing a few days ago and they had to place her on oxygen. She stated her breathing had improved, but she still had a bad cough and some crackles in her lungs. She stated they had a standing order from the physician that they could apply oxygen at 2 liters and titrate according to the resident's oxygen saturation level and resident's comfort. She stated the order should be in the physician orders. LVN F searched the physician orders and MAR, and stated there were no orders put in. She stated she would add the orders now. In an interview with the DON on 02/20/25 at 11:35 a.m., she stated even though they had a standing order list from the physician, the staff had to place those orders into the electronic physician orders which would then populate to the MAR/TAR. She stated the staff had to have an order for the amount of Oxygen to be administered, if it was continuous or as needed, when it was applied and the necessary assessment that needed to be performed for anyone receiving Oxygen therapy. She stated failing to have the order in place, placed a resident at risk lack of continuity of care and the specific amount of Oxygen to be administered. In an interview on 02/20/25 at 11:40 a.m. with LVN G, he stated he worked the night shift on 02/16/25 and stated Resident #64 was on O2 when he arrived. He stated he assessed her vitals and O2 sats and documented in the nurses' notes, but stated he did not check to see if there was an order for the Oxygen. He stated he assumed the order was in place. He stated they were required to have an order for any oxygen administration and the amount to be administered. Record review of the facility's policy titled, Oxygen Therapy, Concentrator-Initiation, dated January 2020, reflected, The licensed staff will provide the prescribed amount oxygen therapy to the residents as prescribed by physician and according to practice guidelines .Procedure: Review physician's orders .Turn liter flow to the prescribed amount .Document in the eMar/eTar ordered oxygen therapy administration .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 34918 Based on observation, interview, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 4 of 10 residents (Resident #23, Resident #22, Resident #72, and Resident #64) observed for infection control. 1. The facility failed to ensure MA C administered Resident 23's medication without cross contaminating her medications on 02/18/25. 2. The facility failed to ensure MA B prepared Resident 72's medication without cross contaminating her medications on 02/18/25. 3. The facility failed to ensure MA B sanitized the blood pressure cuff between use on Resident #22 and Resident #72 on 02/18/25. 4. The facility failed to ensure that CNA D changed her gloves and performed hand hygiene while providing incontinence care to Resident #64 on 02/18/25. 4. The facility failed to ensure the Treatment Nurse used the required PPE for Resident #64, who was on enhanced barrier precautions due to her venous access device and wounds, while performing wound care on 02/19/25. These failures could place the residents at risk of cross-contamination and development of infection. Findings included: 1. During medication observation on 02/18/25 at 08:50 a.m., MA C was observed at the medication cart. MA C performed hand hygiene and prepared Resident #23's morning medications. MA C placed eight medications in one plastic medication cup and 1 medication (iron supplement) in a second medication cup, stating the resident usually refused her iron supplement. MA C entered the resident's room and asked the resident if she wanted her iron supplement. Resident #23 stated she would take her iron supplement. MA C poured the supplement into the cup containing the 8 other medications and handed the pill cup to the resident. Resident #23 poured the medication into her mouth, dropping one of the pills into the crook of her arm. MA C picked up the fallen pill with her bare hands, and placed it into the palm of her hand for Resident #23 to retrieve from her hand. Resident #23 retrieved the pill from MA C palm and took it with the remainder of her medications. In an interview on 02/20/25 at 09:10 a.m. with MA C she stated she realized she had cross contaminated the medication when she touched it with her hand. She stated she should have disposed of the medication and retrieved a new medication. She stated she had been taught they were not supposed to touch any of the medications with their hands due to the risk of cross contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During medication observation on 02/18/25 at 09:15 a.m., MA B was observed at the medication cart in the dining room area on the memory care unit. MA B performed hand hygiene and obtained Resident 22's blood pressure. MA B returned to the medication cart and placed the blood pressure cuff on top of the cart. MA B sanitized her hands and pulled Resident #22's medication and administered his medications to him at the dining room table. MA B returned the medication cart, sanitized her hands and picked up the unsanitized blood pressure cuff and took Resident #72's blood pressure. MA B returned to the medication cart and placed the blood pressure cuff on top of the medication cart. MA B sanitized her hands and opened the medication cart to retrieve Resident #72's medication. MA B pulled keys from her pocket and unlocked the Locked section of the medication cart and retrieved a blister pack containing Resident #72's Xanax (anti-anxiety). MA B punched the blister pack over the plastic medication cup, but the pill remained stuck inside the blister pack. MA B took her finger and pulled the tablet out of the blister pack into the plastic cup. MA B then continued to pull 5 more medications. MA B crushed all the medication except the 1 tablet of potassium (mineral) and then mixed all the pills into yogurt and administered the medications to Resident #72. In an interview with MA B on 02/18/25 at 09:30 a.m., she stated she was supposed to sanitize the blood pressure cuff between resident-use and stated she had forgotten that step. She stated she had been taught they were not supposed to touch any of the medication with bare hands and stated she should have gotten a spoon to retrieve the stuck pill. She stated the reason for not touching the medication and sanitizing the blood pressure cuff was to prevent the spread of germs prevent the spread of infections. In an interview on 02/19/25 at 03:40 p.m. with the DON, she stated the staff were taught to punch the medication directly into the med cup without touching the medication to prevent cross contamination. She stated the staff could have used a spoon to retrieve the medication from the blister pack and should have disposed of the dropped medication and retrieved a new pill. She stated they had all been taught to clean equipment between resident use. She stated they went over and over infection control practice with the staff. 3. In an observation on 02/18/25 at 10:05 a.m., CNA D and CNA E entered Resident #64's room to provide incontinence care. Both staff donned a gown, performed hand hygiene, and put on gloves. CNA D opened the resident's brief and pushed it downward toward the resident's buttocks. CNA D provided peri care from front to back, wiping once and changing wipes with each stroke. Both staff rolled the resident onto her left side. CNA D wiped from front to back, removed her gloves, and performed hand hygiene. CNA D then removed the soiled brief and placed the clean brief under the resident without changing her gloves or performing hand hygiene. Both staff rolled the resident back onto her back and fastened the brief. Both staff removed their gown and gloves and performed hand hygiene. In an interview on 02/18/25 at 10:08 a.m., CNA D stated she should had removed the soiled brief, and then changed her gloves and perform hand hygiene. She stated the way she did it cross contaminated the clean brief and potentially the resident. She stated they had been taught to change their gloves and perform hand hygiene when finished with the dirty and before going to the clean. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. In an observation on 02/19/25 at 10:05 a.m. revealed the Treatment Nurse at the treatment cart preparing wound care supplies for Resident #64's wound to her left heel. The Treatment Nurse placed her supplies on a piece of wax paper and entered Resident #64's room. The Treatment Nurse placed the supplies on the resident's bed, performed hand hygiene and put on gloves, but did not put on a gown. The Treatment Nurse removed the old dressing off her left heel revealing a moderate amount of blood-tinged drainage, removed her gloves and performed hand hygiene and put on clean gloves. The Treatment Nurse cleaned the wound with Normal Saline and applied hydrogel (gel that increases moisture level in the wound) and covered it with a dry dressing. The Treatment Nurse then removed her gloves and performed hand hygiene. In an interview on 02/20/25 at 10:15 a.m. with the Treatment Nurse, she stated she did not think Resident #64 was on Enhanced Barrier precautions because the wound did not have significant drainage and she thought the Resident had a peripheral line, not a PICC line. She stated she was taught that if the resident had a minor wound and a peripheral line, they did not have to use Enhanced Barrier precautions. She stated since the resident did have a PICC line, she should have worn a gown. She stated she was not sure if the wound alone would require a gown. In an interview on 12/05/24 at 11:10 a.m. with the DON, she stated staff were supposed to wash hands and change gloves before and after completion of cleaning a resident, and after completion of care. She stated they had worked so hard with the staff on skills and stated they were all aware of what they were supposed to be doing. She stated the risk of failing to perform hand hygiene was increased infections and cross contamination. She stated any resident with a central line or PICC line required the staff to wear a gown for high contact care. She stated simple skin tears did not require the use of gown but stated Resident #64's wound would not be described as a simple skin tear. She stated they had done training with all the staff on Enhanced Barrier precautions as well as infection control. She stated the reason the residents were placed in Enhanced Barrier precautions was because they were more susceptible to spread of infection and provided an extra level of protection. She stated they did skills checks and education upon hire and annually on infection control, hand hygiene, and Enhanced Barrier precautions, or as needed when training needs were identified. Record review of the facility's policy titled, Disinfecting and Sterilizing Resident Care Equipment, dated January 2022, reflected, Equipment will be maintained and kept sanitized or disinfected in accord with acceptable policies .Only EPA-approved cleaning products and germicides are utilized for the cleaning, disinfection and sterilization of resident equipment .Non-critical items are those that either do not touch the resident or touch only intact skin. Such items include .blood pressure cuffs .These items rarely transmit disease. However, it is imperative that these items are clean . Record review of the facility's policy titled, Medication Administration, dated January 2024, reflected, Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so .hands are washed with soap and water and gloves applied prior to handling tablets . Record review of the facility's policy titled, Hand Hygiene for Staff and Residents, dated January 2022, reflected, .Hand Hygiene is the most important component for preventing the spread of infection .Hand hygiene is done before .resident contact .taking part in a medical or surgical procedure .After contact with soiled or contaminated articles, such as articles that are contaminated body fluids . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy titled, Enhanced Barrier Precautions, dated April 2024, reflected, Many residents in nursing homes are at increased risk of becoming colonized and developing infections with multi-drug resident organisms .Indications .Wounds and/or indwelling medical devices even if the resident is not known to be infection or colonized with an MDRO .High Contact Resident care Activities .Wound care: any skin opening requiring a dressing .EBP are sued in conjunction with standard precautions and expand ethe use of PPE to donning of gown and gloves during high contact care activities that provide opportunities of r transfer of MDROs to staff hands and clothing .