STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675969	A. BUILDING _____ B. WING _____	06/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, 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 one (Resident #1) of 10 residents reviewed for infection control practice. The facility failed to isolate Resident #1 and implement contact isolation precautions when she was readmitted to the facility's memory care unit from the hospital instead of the facility's step-down unit with an unknown COVID-19 status. On 06/02/20 an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 06/04/20, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy with a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. The facility was provided with the IJ template on 06/02/20 at 4:35 PM. This failure placed residents at increased risk of exposure to COVID-19, which could result in illness, hospitalization , or even death. Findings included: Review of Resident #1's face sheet, dated 06/02/20, revealed the resident was a [AGE] year-old female readmitted on [DATE]. Her [DIAGNOSES REDACTED]. Review of Resident #1's admission MDS (Minimum Data Set) assessment, dated 05/12/20, revealed the resident had a BIMS (Brief Interview for Mental Status) score of 0 indicating the resident was cognitively impaired. The resident had a history of [REDACTED]. The resident also required extensive assistance with dressing, toileting, and personal hygiene. Review of Resident #1's Physician Orders, dated 06/01/20, revealed the resident was to be on contact isolation precautions for 14 days. Review of Resident #1's Nurse's Notes from LVN A, dated 06/01/20, revealed the resident was on contact isolation, but moved around the hall and was redirected to her room by staff. Review of Resident #1's Care Plan, dated 05/12/20, revealed the resident was at risk of signs/symptoms of COVID-19 and was unable to participate in social distancing or wearing a face mask when out of her room due to cognitive impairment. Interventions included following the facility's protocol for COVID-19 screening/precautions. Interview with the DON on 06/02/20 at 9:45 AM revealed Resident #1 had readmitted to the facility yesterday (06/01/20) in the evening time. She stated the resident was placed on the memory care unit with other residents. She said Resident #1 had not been tested for COVID-19 and was not showing any signs or symptoms at that time. The DON stated the facility's policy was to quarantine newly admitted residents and residents readmitting to the facility for 14 days on the Step-down Unit. She stated they decided not to follow the policy for residents requiring placement on the memory care unit because they were memory care . She said there was not dedicated staff to Resident #1 and that the staff were caring for Resident #1 and others on the memory care unit. Observation on 06/02/20 at 10:30 AM revealed Resident #1 was in her room on the memory care unit asleep. There were no signs posted inside or outside of the room indicating the resident was on isolation. There was no Personal Protective Equipment (PPE) observed near Resident #1's door, either inside or outside the room. Staff were observed wearing surgical masks and taking care of other residents in the memory care unit. Resident #1 did not have a roommate. An interview with LVN A on 06/02/20 at 10:45 AM revealed that she worked on the memory care unit and Resident #1 readmitted yesterday (06/01/20) from the hospital. She stated the resident was placed in a room on the memory care unit because she wandered often. She stated the resident was on isolation precautions, and staff were wearing gloves and a surgical mask while caring for her. She said staff should be wearing a gown and gloves when caring for the resident and there was one gown in the room. She said Resident #1 was up most of the night and needed constant redirection as she was out of her room often. She said they had tried to keep her in the room as much as possible but it was difficult. An interview with RN B on 06/02/20 at 11:00 AM revealed she worked on the memory care unit and Resident #1 readmitted yesterday (06/01/20) from the hospital. She stated the resident wandered a lot and was on the memory care unit for her wandering. She stated the resident was often out of her room and needed constant redirection although she was supposed to stay in her room. She stated that she was not assigned to that resident but knew she was supposed to be on contact isolation precautions. She said staff should have been wearing a gown and gloves when caring for the resident. An interview with CNA C on 06/02/20 at 4:07 PM revealed she worked on the memory care unit and that Resident #1 was readmitted yesterday (06/01/20) to the memory care unit. She said she was never told Resident #1 was supposed to be on isolation precautions. She said she knew Resident #1 was supposed to be placed on the Step-down Unit for 14 days upon readmission, but that was not what the facility was doing. She said that she was wearing a surgical mask and gloves to care for the resident. An interview with CNA D on 06/04/20 at 10:00 AM revealed she worked on the memory care unit and that Resident #1 was readmitted yesterday (06/01/20) to the memory care unit. She said she was not told the resident should have been on isolation precautions. She said she knew Resident #1 should have been on the Step-down Unit for 14 days because she returned from the hospital and could have been exposed to COVID-19. She said that she had spoken to the Administrator and DON about residents on the memory care unit returning and not being quarantined or isolated as they should have been. She said that she was told it was fine and that staff were educated on how to care for the readmitted residents. She said that they wore surgical masks and gloves when caring for the resident. She said that Resident #1 was hard to redirect and was often out of her room. An interview with the Administrator and DON on 06/02/20 at 11:30 AM revealed that Resident #1 was on the memory care unit with the other residents after readmitting yesterday (06/01/20). The Administrator and DON stated their policy was for all readmits and new admits to be quarantined for 14 days on their Step-down Unit. They stated the memory care unit residents were placed on the memory care unit and not on the Step-down unit for 14 days. They stated they did not have a separate area for isolation or dedicated staff for the residents on isolation on the memory care unit. They stated they planned to move Resident #1 from the memory care unit and place her on the Step-down Unit to be quarantined for 14 days with one-on-one care for redirection. The DON said that she knew the hospital where Resident #1 discharged from did not have any positive COVID-19 patients, so she did not think it was an issue. The DON stated that she followed up with the hospital to ensure they did not have any positive patients by calling them. The DON and Administrator said that they put general population admits/readmits and memory care new admits on the Step-down Unit for 14 days but did not use the same practice for memory care readmits. They stated that they had their staff wearing masks and using gloves and gowns to care for isolated residents. They stated that they did not have dedicated staff to the re-admits or new admits on the memory care unit. They stated that they expected staff to wear the items outside of the door for precautions and that staff were to review the orders for isolation. They stated that staff had not told them there was not PPE available, signs posted, or any wandering concerns from the resident. An interview with the Medical Director on 06/02/20 at 3:27 PM revealed that all residents that admitted or readmitted to the facility should be placed in the facility's Step-down Unit which was separated from all other residents and were quarantined for suspected COVID-19. He stated even memory care residents that met the admission/readmission criteria should also be quarantined from other memory care unit residents. Review of the facility's policy Coronavirus Management Plan Phase 2, undated, revealed Develop a 'Step-down Unit' for all new admits. This unit is for asymptomatic new admissions. . New residents will stay in this unit for 14 days before being moved to the regular population. Review of the CDC's Guidance on Preparing for COVID-19 in Nursing Homes revealed: Create a Plan for Managing New Admissions and Readmissions Whose COVID-19

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

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.

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) Status is Unknown .placing the resident in a separate observation area so the resident can be monitored for evidence of COVID-19 .residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Accessed from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html titled An IJ was identified on 06/02/20, and the Administrator and DON were notified of the IJ. A plan of removal to remove the immediacy was requested on 06/02/2020 at 5:00 PM. The following plan of removal was accepted on 06/03/20 at 8:47 PM. The following is a plan of removal to the IJ called for the facility's alleged violation of Infection Control failure to create a plan for memory care unit re-admissions. o The Administrator, made the notification of IJ status to the Medical Director, on 06/02/2020 at 6:10 pm. The Medical Director is available to the team as needed. o Quality Assurance / Process Improvement meeting scheduled for 06/03/2020 at 9:00 am. o On 06/02/2020, the DON conducted an audit of re-admissions to (Facility name) for the past 14 days and identified three residents with recent re-admissions. All three of these residents were immediately moved on 06/02/20 to the step-down unit, and their respective representatives notified. The residents were moved, per facility's procedure, that all new and re-admissions are to be admitted to a step-down unit for 14 days of monitoring for signs and symptoms of COVID-19. Additionally, they will be monitored for change of condition, including signs of behavioral and emotional distress. o The findings of the audit noted the COVID-19 status of the three residents as follows: o Resident #1 re-admitted on [DATE] and was not tested in the acute care hospital due to not meeting criteria o Resident #2 re-admitted on [DATE] and tested negative for COVID-19 at the acute care hospital prior to admission to (Facility name) o Resident #3 re-admitted on [DATE] and was not tested in the acute care hospital o On 06/02/2020, the DON audited all physician orders [REDACTED]. The audit found that physician ordered isolation precautions needed to be initiated for the three residents listed above. Isolation precautions were initiated for the three respective residents on 06/02/2020. o The DON or designated nurse manager will audit new orders daily to identify residents with physician ordered transmission-based precautions. o Clinical staff will be trained on the plan created for re-admissions to the facility. The facilities plan is for all new and re-admissions to be admitted to a step-down unit for 14 days of monitoring for signs and symptoms of COVID-19. (DON) or designated nurse manager will review all admissions daily to assure proper placement. o Starting 06/03/2020 and ongoing all memory care re-admissions' COVID-19 status will be monitored, by the DON or designated nurse manager, through review of the Hospital to Post-Acute Care Facility Transfer-COVID-19 Assessment prior to admission to (Facility name). Beginning 06/02/20 and ending on 06/04/20, Clinical Staff, Management Staff, and Nursing Staff will be trained on Memory Care Resident Re-admission Plan. Beginning 06/02/20 and ending on 06/04/20, Licensed Nurses will be trained on Following Physician order [REDACTED]. Monitoring of the plan of removal included the following: Observations made on 06/03/2020 at 10:00 AM revealed that the three re-admits from the memory care unit had been placed on the step-down. Resident #1 was observed in a room on the step-down unit where staff were using gowns, gloves, and N95 masks to care for the residents. Isolation precaution signs were also posted on the door of Resident #1's room to alert staff as to what PPE was required prior to entering. Interviews were conducted on 06/04/20 from 9:00 AM to 3:00 PM with the following staff: the Administrator, the DON, the ADON, LVN A, RN B, CNA C, CNA D, CNA E, LVN F, CNA G, LVN H, LVN I, MA J, CNA K, CNA L, CNA M, LVN N, CNA O, MA P, LVN Q, CNA R, CNA S. These interviews with staff confirmed they had been in-serviced on all readmissions or new admissions to the facility. The staff revealed residents were to be placed on the Step-down Unit for 14 days to be monitored for signs and symptoms of COVID-19 . The staff also stated their understanding of contact precautions for newly admitted or readmitted residents. On 06/02/20 an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 06/04/20, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy with a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their plan of removal.