STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676101	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgmar Medical Lodge	6600 Lands End Court Fort Worth, TX 76116

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview, and record review, the facility failed to implement written policies and procedures that prohibit and prevent neglect and misappropriation for two of two incidents (Resident #162 and Resident #300) reviewed for reporting. 1. The facility failed to follow their policy to report to the State Survey Agency when Resident #162 was found in bed and had been bitten by fire ants. 2. The Administrator, who was the Abuse Prevention Coordinator, failed to follow their policy to report to the State Agency and initiate an investigation after being informed of a written allegation of misappropriation made by Resident #300's family member. This failure could place the residents in the facility at risk of continued abuse and neglect. Findings included: Record Review of the facility's policy titled Abuse and Reporting Policy revised July 2017, reflected the following: Policy: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Reporting 1. All alleged violations including abuse, neglect, exploitation, or mistreatment, including injuries of an unknow source, and misappropriation of property will be reported by the facility administrator, or his or her designee, to the following persons or agencies; a. The State licensing/certification agency responsible for surveying/licensing the facility. (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: 676101	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Ridgmar Medical Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 6600 Lands End Court Fort Worth, TX 76116	

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #162's quarterly MDS dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included hypertension (high blood pressure), aphasia (a language disorder that makes it difficult to understand and express written and spoken language), stroke, hemiplegia (total or partial paralysis of one side of the body), nontraumatic subarachnoid hemorrhage (intracranial bleeding), and difficulty in walking. Resident #162 had a BIMS of 7 which mean his cognition was severely impaired. The MDS further reflected the resident had impairment to one side of his upper and lower extremities. Resident #162 was dependent upon staff for all ADLs. Review of Resident #162's care plan revised on 09/18/24 reflected the resident had an ADL self-care performance deficit related to immobility. Interventions included needing assistance from staff for all ADLs. The care plan further reflected the resident had a communication problem related to the diagnosis of aphasia. Interventions included to allow adequate time to respond, repeat as necessary, do not rush and request clarification from the resident to ensure understanding. Review of Resident #162's weekly body audit dated 10/21/24 reflected he had ant bites to the right and left side of his abdomen. Review of Resident #162's progress notes dated 10/22/24 reflected the following: Benadryl Allergy Oral Capsule 25MG Give 1 tablet by mouth every 6 hours as needed for itching Observation and interview with Resident #162 on 11/12/24 at 1:23 PM revealed he was in his room sitting in a gerichair. The resident was opening and closing his eyes and when asked how he was doing, he quietly whispered he was ok. The resident was asked if he recalled being bitten by ants and the resident was attempting to speak but closed his eyes and did not respond. Interview on 11/12/24 at 5:15 PM with LVN H revealed CNA BB alerted her that Resident #162 had been found in bed with ants that had been bitten, 10/21/24. LVN H said when she went in the resident's room, she did not see any ants but said Resident #162 was not able to call for help or use his call light due to his condition. She called the doctor and Benadryl was ordered for any discomfort. Interview on 11/13/24 at 1:48 PM with CNA BB revealed she had gone to check on Resident #162 around 7AM and as she pulled the cover back off the resident, she noticed there were a lot of little red ants on the bed and on the resident, 10/21/24. The Wound Care Nurse was in the room at the time the ants were found. CNA BB said as they were trying to strip the bed of the covers, the ants were crawling on her hands as well. Once they got all the ants off the resident and the bed, she noticed Resident #162 had bites on the sides of his abdomen, and his back and also noticed there were food crumbs in his bed. She said Resident #162 did not appear to be in any distress or pain at the time, and was just laying there. CNA BB stated she did not think the resident was able to register what had happened. The resident was taken to the shower right after to make sure all the ants had gotten off him. CNA BB said she worked with Resident #162 again about two days later and during his shower, she had noticed the ant bites had turned in to small pustules. CNA BB further stated that was the first time she had seen any ants in any room or that anyone had been bit. She did not look to see where the ants had come in from because everything happened so fast. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/13/24 at 3:29 PM with the Wound Care Nurse revealed she had gone into Resident #162's room for wound care, 10/21/24 and noticed there were ants on his foot and the wound dressing. She immediately took the covers off Resident #162 and noticed he had been bit on his torso, his stomach and possibly his legs. The resident did not appear to be in any distress at the time and was just laying there. Resident #162 was cleaned up and taken to the shower by the aide. The Wound Care Nurse said she noticed a banana peel on the floor and saw ants around that but did not notice where they had come in from. The Wound Care Nurse further stated she was not aware of any other resident being bit and had never seen any ants in other rooms. Observation and interview on 11/12/24 at 3:32 PM with Pest Control revealed he was onsite at the facility treating/spraying one of patios. He said he regularly serviced the facility and had been called after the incident, 10/21/24, because ants had been found in the interior of the facility in the 500 rooms. Once he arrived on 10/23/24, he did not see any active ants inside the rooms and when he treated the outside, he found 3 mounds of fire ants and they had been up against the wall of the 500 hall, where Resident #162 had resided at the time he was bitten. Review of the Pest Control log book on 11/14/24 reflected the facility had been treated on the following dates: 10/08/24 - preventative maintenance treatment throughout the exterior perimeter and service rodent bait stations. No reported activity by [Maintenance Director] 10/23/24 - serviced rooms 501, 502, 504, 506, 507, 508, 509, for ants and treated kitchen. 11/13/24 - treated the exterior perimeter and ant [NAME] against the building and the surrounding areas of the exterior of building perimeter where they found active [NAME] against the sidewalk close to the fire hydrant and also treated both courtyards. 2. Record review of Resident #300's MDS reflected the resident was a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #300 discharged on [DATE]. His diagnoses included renal insufficiency, anemia, liver transplant status, and septicemia. Resident #300 had a BIMS of 8 suggesting the resident has moderate cognitive impairment. Interviews were attempted with complainant on 11/12/24 at 10:10 AM, 11/13/24 at 2:22 PM, and 11/14/24 at 1:46 PM. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Administrator on 11/14/24 at 2:01 PM revealed that Administrator had been employed at the facility for four months. Administrator stated that Resident #300's family came to the facility on [DATE] and picked up the resident's personal belongings. Administrator said that the family called about a week later and stated that the resident's phone and wallet were missing. Administrator stated that he went and checked the nurses' carts, rooms, etc. but could not located the missing items. Administrator revealed that he interviewed the staff the following day and determined that a CNA observed the emergency transport company place the resident's wallet and phone on the resident before they wheeled him out of the facility. Administrator stated that he phoned the family and suggested that they call the ambulance/transport company or hospital to determine if they had seen the wallet and phone. Administrator said that the family filed a police report, and the police came and interviewed him about the missing wallet and phone. Administrator was unable to provide documentation about the police interview/investigation. Administrator revealed that he did not file a report with State Survey Agency because he did not believe the wallet and phone were stolen. Administrator stated that he did not know the facility policy of an allegation of misappropriation of resident property. Administrator revealed that what he normally does when he has an allegation of misappropriation of property was first search for the missing item. If the item was not found, he reported it to State Survey Agency, resident's physician, ombudsman, responsible part, APS, and law enforcement. Record review of October 2024 grievances reflected no grievances regarding the resident's missing items. 48236

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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** 32227 Based on observation, interview, and record review, the facility failed to ensure in response to allegations of abuse, neglect, exploitation, or mistreatment that all alleged violations involving abuse, neglect, exploitation or mistreatment were reported immediately or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to the Stat Survey Agency in accordance with State law through established procedured for two of two incidents (Resident #162 and Resident #300) reviewed abuse, neglect, and misappropriation. 1. The facility failed to report to the State Survey Agency when Resident #162 was found in bed and had been bitten by fire ants. 2. The Administrator, who was the Abuse Prevention Coordinator, failed to report to the State Survey Agency and initiate an investigation after being informed of a written allegation of misappropriation made by Resident #300's family member. This failure could place the residents in the facility at risk of continued abuse and neglect. Findings included: 1. Record review of Resident #162's quarterly MDS dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included hypertension (high blood pressure), aphasia (a language disorder that makes it difficult to understand and express written and spoken language), stroke, hemiplegia (total or partial paralysis of one side of the body), nontraumatic subarachnoid hemorrhage (intracranial bleeding), and difficulty in walking. Resident #162 had a BIMS of 7 which mean his cognition was severely impaired. The MDS further reflected the resident had impairment to one side of his upper and lower extremities. Resident #162 was dependent upon staff for all ADLs. Record review of Resident #162's care plan revised on 09/18/24 reflected the resident had an ADL self-care performance deficit related to immobility. Interventions included needing assistance from staff for all ADLs. The care plan further reflected the resident had a communication problem related to the diagnosis of aphasia. Interventions included to allow adequate time to respond, repeat as necessary, do not rush and request clarification from the resident to ensure understanding. Record review of Resident #162's weekly body audit dated 10/21/24 reflected he had ant bites to the right and left side of his abdomen. Record review of Resident #162's progress notes dated 10/22/24 reflected the following: Benadryl Allergy Oral Capsule 25MG Give 1 tablet by mouth every 6 hours as needed for itching (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	Observation and interview with Resident #162 on 11/12/24 at 1:23 PM revealed he was in his room sitting in a gerichair. The resident was opening and closing his eyes and when asked how he was doing, he quietly whispered he was ok. The resident was asked if he recalled being bitten by ants and the resident was attempting to speak but closed his eyes and did not respond. Interview on 11/12/24 at 5:15 PM with LVN H revealed CNA BB alerted her that Resident #162 had been found in bed with ants that had been bitten, 10/21/24. LVN H said when she went in the resident's room, she did not see any ants but said Resident #162 was not able to call for help or use his call light due to his condition. She called the doctor and Benadryl was ordered for any discomfort. Interview on 11/13/24 at 1:48 PM with CNA BB revealed she had gone to check on Resident #162 around 7AM and as she pulled the cover back off the resident, she noticed there were a lot of little red ants on the bed and on the resident, 10/21/24. The Wound Care Nurse was in the room at the time the ants were found. CNA BB said as they were trying to strip the bed of the covers, the ants were crawling on her hands as well. Once they got all the ants off the resident and the bed, she noticed Resident #162 had bites on the sides of his abdomen, and his back and also noticed there were food crumbs in his bed. She said Resident #162 did not appear to be in any distress or pain at the time, and was just laying there. CNA BB stated she did not think the resident was able to register what had happened. The resident was taken to the shower right after to make sure all the ants had gotten off him. CNA BB said she worked with Resident #162 again about two days later and during his shower, she had noticed the ant bites had turned in to small pustules. CNA BB further stated that was the first time she had seen any ants in any room or that anyone had been bit. She did not look to see where the ants had come in from because everything happened so fast. Interview on 11/13/24 at 3:29 PM with the Wound Care Nurse revealed she had gone into Resident #162's room for wound care, 10/21/24 and noticed there were ants on his foot and the wound dressing. She immediately took the covers off Resident #162 and noticed he had been bit on his torso, his stomach and possibly his legs. The resident did not appear to be in any distress at the time and was just laying there. Resident #162 was cleaned up and taken to the shower by the aide. The Wound Care Nurse said she noticed a banana peel on the floor and saw ants around that but did not notice where they had come in from. The Wound Care Nurse further stated she was not aware of any other resident being bit and had never seen any ants in other rooms. Observation and interview on 11/12/24 at 3:32 PM with Pest Control revealed he was onsite at the facility treating/spraying one of patios. He said he regularly serviced the facility and had been called after the incident, 10/21/24, because ants had been found in the interior of the facility in the 500 rooms. Once he arrived on 10/23/24, he did not see any active ants inside the rooms and when he treated the outside, he found 3 mounds of fire ants and they had been up against the wall of the 500 hall, where Resident #162 had resided at the time he was bitten. Record review of the Pest Control log book on 11/14/24 reflected the facility had been treated on the following dates: 10/08/24 - preventative maintenance treatment throughout the exterior perimeter and service rodent bait stations. No reported activity by [Maintenance Director] 10/23/24 - serviced rooms 501, 502, 504, 506, 507, 508, 509, for ants and treated kitchen. (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	11/13/24 - treated the exterior perimeter and ant [NAME] against the building and the surrounding areas of the exterior of building perimeter where they found active [NAME] against the sidewalk close to the fire hydrant and also treated both courtyards. 2. Record review of Resident #300's MDS reflected the resident was a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #300 discharged on [DATE]. His diagnoses included renal insufficiency, anemia, liver transplant status, and septicemia. Resident #300 had a BIMS of 8 suggesting the resident has moderate cognitive impairment. Interviews were attempted with complainant on 11/12/24 at 10:10 AM, 11/13/24 at 2:22 PM, and 11/14/24 at 1:46 PM. Interview with Administrator on 11/14/24 at 2:01 PM revealed that Administrator had been employed at the facility for four months. Administrator stated that Resident #300's family came to the facility on [DATE] and picked up the resident's personal belongings. Administrator said that the family called about a week later and stated that the resident's phone and wallet were missing. Administrator stated that he went and checked the nurses' carts, rooms, etc. but could not located the missing items. Administrator revealed that he interviewed the staff the following day and determined that a CNA observed the emergency transport company place the resident's wallet and phone on the resident before they wheeled him out of the facility. Administrator stated that he phoned the family and suggested that they call the ambulance/transport company or hospital to determine if they had seen the wallet and phone. Administrator said that the family filed a police report, and the police came and interviewed him about the missing wallet and phone. Administrator was unable to provide documentation about the police interview/investigation. Administrator revealed that he did not file a report with State Survey Agency because he did not believe the wallet and phone were stolen. Administrator stated that he did not know the facility policy of an allegation of misappropriation of resident property. Administrator revealed that what he normally does when he has an allegation of misappropriation of property was first search for the missing item. If the item was not found, he reported it to State Survey Agency, resident's physician, ombudsman, responsible part, APS, and law enforcement. Record Record review of October 2024 grievances reflected no grievances regarding the resident's missing items. Record Record review of the facility's policy titled Abuse and Reporting Policy revised July 2017, reflected the following: Policy: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Reporting 1. All alleged violations including abuse, neglect, exploitation, or mistreatment, including injuries of an unknow source, and misappropriation of property will be reported by the facility administrator, or his or her designee, to the following persons or agencies; (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	a. The State licensing/certification agency responsible for surveying/licensing the facility. 48236

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on interview and record review, the facility failed to incorporate the recommendations from the PASARR Level II determination and the PASARR evaluation report for 2 of 5 residents reviewed (Residents #15 and #80) for PASARR assessments. 1. The facility failed to submit a Nursing Facility Specialized Services (NFSS) form requested by the specific deadline for Resident #15. 2. The facility did not refer Resident #80 to the appropriate state-designated mental health authority for review when he received a new diagnosis of schizoaffective disorder. This failure could affect residents with psychiatric diagnoses who may not be evaluated and receive needed PASRR services. Findings included: 1. Record review of Resident #15's Quarterly MDS Assessment, dated 09/13/24, reflected a BIMS score was not completed. Resident #15 was noted to have impairment to both sides of his upper and lower extremities but did not use any of the mobility devices listed. Resident #15 was dependent (meaning helper does all of the effort and the resident does none of the effort to complete the activity) for chair/bed-to-chair transfers. Resident #15's diagnoses included other neurological conditions (any disorder of the nervous system), cerebral palsy (a group of disorders that affect movement and muscle tone or posture), and seizure disorder or epilepsy (a chronic brain disorder in which groups of nerve cells, or neurons, in the brain sometimes send the wrong signals and cause seizures). Record review of Resident #15's care plan reflected the following: Focus: PASRR positive R/T pt identified as having PASRR positive status related to an intellectual disability .MHMR of [County Name]. PCSP 7/25/24. Habilitation Coordination, ILS, PT and CMWC .Goal: will maintain highest level of practice wellbeing for the next 90days .Interventions: provide service coordination with representative from LIDDA .[sic]. Record review of Resident #15's Care Plan Conference document, dated 07/25/24, reflected under Additional Comments was the following: .starting pt assessment and get new w/c. Record review of Resident #15's Habilitative Service Plan (HSP) dated 07/25/24 reflected the following: Section 6, NF Specialized Services to be Monitored by the SPT .Name of Service: Customized Manual Wheelchair . signed by the Habilitation Coordinator. Record review of Resident #15's PCSP Form, dated 07/25/24, reflected under the section Nursing Facility Specialized Services, a number 2 was marked next to Customized Manual Wheelchair (CMWC) which indicated it was new. Under the comments section next to Nursing Facility Comments reflected: Accepted services of customized wheelchair, ILS, Hab coordination and PT with assessment. [sic]. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of an email provided by the DOR, dated 08/23/24, reflected it was an email to the previous MDS Coordinator from the DOR providing the documents needed to submit for Resident #15's customized wheelchair. The email included attachments including a quote, dated 08/21/24, from a DME company for Resident #15's customized wheelchair and a signed CMWC Supplier Acknowledgement and Signature Page dated 08/23/24. Telephone interview on 11/08/24 at 2:43 PM with Resident #15's HC revealed Resident #15 had his annual PASRR meeting on 07/25/24 when a manual wheelchair was added to his treatment plan. Resident #15's HC said she came back a month later and the facility had not made any progress on it. Resident #15's HC said the facility had 20 business days or 30 calendar days to initiate the service that was added from the 07/25/24 meeting. Resident #15's HC said she knew the facility had lots of staff changes recently so it was hard to stay in contact and get a status update. Observation and an attempted interview on 11/13/24 at 9:25 AM of Resident #15 revealed he was in his bed in his room, his bed was very low to the ground and a fall mat was at his bedside. Resident #15's geri-chair was across the room. Resident #15 was not able to answer questions due to his condition although he appeared to be okay. Interview on 11/13/24 at 12:10 PM with MDS Coordinator QQ revealed she just started at the facility a month ago and had not had the opportunity to work on Resident #15's PASRR services yet. MDS Coordinator QQ said she was in attendance for Resident #15's recent annual PASSR meeting and the wheelchair was marked as ongoing on the PCSP. MDS Coordinator QQ said she looked in the database and saw that that DME (the wheelchair) was initially started on 07/25/24. MDS Coordinator QQ said once something like DME was initiated, the therapy department was responsible for ensuring it was carried out. MDS Coordinator QQ said she was only responsible for uploading the receipts in the database. Interview on 11/13/24 at 12:25 PM with the DOR revealed he remembered bringing in a vendor to get Resident #15 evaluated for a wheelchair based on a referral that was made. The DOR said from there he sent over the quote and forms to the previous MDS Coordinator to be uploaded in the database and sent to the PASSR unit for approval. The DOR said the CMWC was signed 08/23/24 and the vendor came out a few days before that. The DOR said he never received any follow-up or heard anything more about Resident #15's wheelchair. Follow-up interview on 11/14/24 at 5:11 PM with MDS Coordinator QQ revealed she was responsible for ensuring all PASSR paperwork was submitted through the database in a timely manner. MDS Coordinator QQ said if PASRR paperwork was not submitted through the database timely, residents could miss out on services. 2. Record review of Resident #80's face sheet, dated 11/14/24 reflected he was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #80 was diagnosed with schizoaffective disorder, unspecified on 03/06/24. Record review of Resident #80's Quarterly MDS Assessment, dated 10/14/24, revealed a BIMS score of 14, which indicated his cognition was intact. MDS further revealed resident had an active diagnosis of schizophrenia disorder. Record review of Resident #80's undated Care Plan reflected The resident uses psychotropic medications r/t Bipolar, mood disorder, Schizoaffective. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #80's PASRR Level 1 Screening, dated 01/18/22, reflected he did not have a mental illness. Interview on 11/13/24 at 3:06 PM with the MDS Coordinator QQ revealed Resident #80 was given a diagnosis of schizoaffective disorder on 03/06/24. She stated the only PASRR they have on file was for 01/18/22. She stated due to the new diagnosis Resident #80 required a new PASRR evaluation. She stated it was the responsibility of MDS Coordinators for submitting PASSR's whether for newly admitted residents or related to updates for new diagnoses for residents. She stated she had been employed since 10/07/24, and was not employed when Resident #80 was given the diagnosis. She stated she was not sure why it was not done. She stated upon employment she completed a general audit on resident clinical records but did not complete an audit on PASRRs. The MDS Coordinator QQ stated by not reviewing resident PASRR screenings along with diagnoses, placed residents at risk of not receiving needed services. Interview on 11/14/24 at 4:01 PM with the Administrator revealed the MDS Coordinators were responsible for updating the PASSR assessments and submitting them timely but had no information regarding Resident #80 PASRR. He stated MDS Coordinators kept track of all PASRRs, and the [NAME] Nurse would ensure PASRR were completed and submitted. He stated PASRR audits were completed prior to him being employed in July 2024. Record review of the facility's Preadmission and Screening Resident Record review (PASRR) Rules policy, dated 03/15/23, reflected the following: It is the intent of Priority Management Group to meet and abide by all State and Federal regulations that pertain to resident Preadmission and Screening Resident Record review (PASRR) Rules . When it is determined that an individual's diagnosis was changed and /or a state surveyor determines the PL1 was incorrect, the social worker or designee will complete and submit a form 1012 (MI) or new PL1 (ID/DD). A subsequent positive PL1 will be entered according to 1012 findings. 44140

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676101	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgmar Medical Lodge	6600 Lands End Court Fort Worth, TX 76116

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for 2 of 5 residents (Resident #55 and Resident #10) reviewed for quality of care. 1. The facility failed to ensure LA Z did not pick Resident #55 up and place her in her wheelchair before a nurse was able to complete an assessment after she fell out of her wheelchair onto the hard-wood floor in the dining room on 11/12/24. Resident #55 was seen on the floor with a pool of blood around her head and was moaning in pain after she fell . The facility failed to ensure CNA Y did not remove Resident #55 from the dining room area after she had a fall from her wheelchair, before she could be assessed by a nurse, and while she was actively bleeding from her head. 2. The facility failed to ensure Resident #10's dressings on her left heel, leg, and right hip were dated as per the facility policy. These failures could place residents at risk of not receiving necessary medical care, harm, and death. Findings included: 1. Record review of Resident #55's Admission Record, dated 11/12/24, reflected the resident was an [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #55's Quarterly MDS Assessment, dated 08/26/24, reflected she had a BIMS score of 00 indicating severe cognitive impairment. Resident #55 was noted to use a wheelchair and required substantial/maximal assistance (meaning helper did more than half of the effort) for sit to stand transfers. Resident #55's active diagnoses included non-traumatic brain dysfunction (brain injuries not caused by external force), non-alzheimer's dementia (the loss of memory and other intellectual functions severe enough to cause problems in one's abilities to perform their usual daily activities), and senile degeneration of the brain (a decline in cognitive function, memory, and behavioral abilities). Resident #55 was also noted to have had falls since the prior assessment was completed that resulted in two or more falls with and without injuries. Record review of Resident #55's Physician's Orders reflected the following: Clean abrasion to right forehead with wound cleaner then pat dry leaving open to air daily every day shift for abrasion with a start date of 11/12/24. Record review of Resident #55's Care Plan reflected the following: Focus: The resident has had an actual fall .Goal: The resident will resume usual activities without further incident through the review date . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #55's Fall Risk Screening, dated 11/12/24, reflected a score 15, indicating a high fall risk. Record review of Resident #55's Progress notes reflected the following: - the Wound Care Nurse on 11/12/24 at 11:00 AM wrote: Res was found on the floor in the dining room attempting to stand without assistance losing balance falling to the floor. Facility staff observed blood coming from face and resident continued attempting to stand unassisted. Facility staff alerted nursing staff of situation. Facility staff assisted resident to wheelchair then to nurse's station. Res is transferred by this nurse writer from wheelchair to bed for full assessment including pain, skin, rom. Abrasion cleaned with normal saline then bandage applied. Neuros started Doctor, DON notified, hospice and [family member] notified as well. Observation and interview on 11/12/24 at 10:00 AM of the 600-hallway revealed LA Z asking for a nurse because a resident had fallen on the hard-wood floor in the dining room. This surveyor walked down the 600-hall to find a nurse and went to the dining room to check on the resident. LA Z was kneeled next to Resident #55 who was laying on the floor on her stomach with a pool of blood coming from her head. Resident #55 was observed to be moaning. This surveyor went to another nurse's station and then back down the 600-hall trying to find the nurse when LA Z was seen transferring Resident #55 to her wheelchair while pressing linen to her head where she was bleeding from. This surveyor found CNA Y in a resident's room and explained to her that LA Z had just picked up Resident #55 and placed her in her wheelchair after she had fallen and hit her head and was bleeding. The surveyor asked CNA Y where the nurse was and to check on Resident #55 in the meantime. The surveyor went to the front to have a nurse paged to the dining room as a resident had fallen and the nurse could not be located. The surveyor began walking down the 600-hall again and saw CNA Y wheeling Resident #55 down the hall away from the dining room while pressing linen to her head where she was bleeding from. CNA Y brought Resident #55 to the nurse's station where a nurse met them with a treatment cart. Resident #55 was grimacing and moaning. Observation and interview on 11/12/24 at 10:25 AM of Resident #55 revealed she was sitting in her wheelchair in a common area of the facility. Resident #55 had a large knot on the right side of her forehead with a laceration in the middle of it. Resident #55 said she fell down and hurt herself really bad, but someone picked her up from the floor and put her in her wheelchair. Resident #55 said her head was hurting but she did not have pain anywhere else. Observation on 11/12/24 at 10:30 AM of the dining room revealed it was hard-wood floor and had a yellow wet floor cone that was covering a recently mopped area where Resident #55 had just fallen earlier. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Ridgmar Medical Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 6600 Lands End Court Fort Worth, TX 76116	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/12/24 at 10:56 AM with LA Z revealed he had been employed at the facility for three months. LA Z said he saw a resident had fallen out of their wheelchair in the dining room and as he got closer he realized it was Resident #55. LA Z said he looked down the 600-hall to see if a CNA or nurse was there and could not find anyone but saw a female walk out of a room pushing desk and a clipboard. LA Z asked that person if a nurse was nearby and saw them take off assuming they were looking for a nurse. LA Z said he looked back at Resident #55 and saw blood dripping from her head so he grabbed a pillow case to put on her head. LA Z said he then picked Resident #55 up to put her in her wheelchair to get help at the nurse's station. LA Z said he picked Resident #55 up because he saw her trying to get up on her own and saw the blood coming from her head. LA Z said when he finished putting Resident #55 in her wheelchair he saw a female and a CNA coming out of one of the rooms behind him. LA Z said then the CNA ended up pushing Resident #55 in her wheelchair to the nurse's station. LA Z said he then took off to get a housekeeper to clean and mop up the blood from the dining room floor. LA Z said the CNA told him he was supposed to leave Resident #55 on the floor until a nurse could assess her before moving her. LA Z said the CNA also told him to go wash his hands because he had blood on them and did not use any gloves when he put the pillowcase to her head to stop the bleeding. LA Z said he was not trained before today (11/12/24) on what to do if a resident had a fall. Interview on 11/12/24 at 11:14 AM with CNA Y revealed she came out of a room on the 600-hall when the surveyor came to get her. CNA Y said she walked down the dining room with the surveyor while she explained that Resident #55 had fallen and was bleeding from her head. CNA Y said when she got to the scene LA Z had pick Resident #55 up and placed her in her wheelchair. CNA Y said she saw Resident #55's head was bleeding and there was a pillowcase on her head. CNA Y said the surveyor had explained that someone was coming to the dining room but there was so much going through her mind at the time. CNA Y said her first thought was to stop and make sure Resident #55 was okay and normally people would come to the location to care for the resident where they fell . CNA Y said the fact that LA Z had already picked Resident #55 up from the floor and no one was around, she decided to wheel her to find a nurse. CNA Y said she should have stayed in the dining room area with Resident #55 while the surveyor went to look for the nurse. CNA Y said it could have caused further harm to the resident by moving her and she should not have wheeled her away from the area to the nurse's station. CNA Y said she had been trained before today (11/12/24) to leave the resident where they were and to not move them before the nurse could assess her. Interview on 11/12/24 at 11:20 AM with HK X revealed she knew to not move or pick up a resident if they had a fall but she had not been trained by the facility. Interview on 11/12/24 at 11:27 AM with CNA W revealed she would move a resident from the scene of a fall if they were picked up by someone else before the nurse was able to assess them. CNA W said she had not been trained on what to do when a resident has had a fall before today (11/12/24). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/12/24 at 12:25 PM with the Wound Care Nurse revealed she was told Resident #55 had fall on the floor and was transferred from the floor to the wheelchair. The Wound Care Nurse said she did a full assessment on Resident #55 after taking her to her room. The Wound Care Nurse said a full skin assessment was completed and neuro checks were started. The Wound Care Nurse said during the assessment she noted Resident #55 had a skin tear to her forehead that was red with granulated tissue and swollen. The Wound Care Nurse said Resident #55 told her that she was picking things up off the floor and then boom and that guy picked her up like a baby and put her in the chair and then [the Wound Care Nurse] came. The Wound Care Nurse said Resident #55 was on routine pain medicine and she did not have any pain anywhere else. The Wound Care Nurse said staff were not allowed to move a resident after they've had a fall because the nurse needed to complete an assessment. The Wound Care Nurse said LA Z should not have picked Resident #55 up and CNA Y should not have wheeled her away from the area. Interview on 11/12/24 at 1:00 PM with the ADON revealed she heard the page overhead for a nurse to come down to the dining room. The ADON said she later saw Resident #55 at lunch eating and saw she had an abrasion to her forehead. The ADON said if a resident had a fall, the staff who found her should get a nurse immediately. The ADON said the resident had to be assessed by a licensed nurse before being moved in anyway. The ADON said LA Z told her he did pick up Resident #55 before she was assessed by a nurse. The ADON said she also saw CNA Y wheeling Resident #55 down the hallway before she was assessed by a nurse. Interview on 11/12/24 at 1:23 PM with the DON revealed LA Z saw Resident #55 on the floor and hollered out for a nurse. The DON said LA Z picked up Resident #55 from the floor and put her in her wheelchair. The DON said CNA Y then walked around the corner and saw Resident #55 in her wheelchair and did not see a nurse so rolled the resident to the nurse's station. The DON said Resident #55 was assessed by a nurse and was noted to have a head injury. The DON said Resident #55 must have hit her head on the floor because she had a round bruised area to the right side on her forehead. The DON said Resident #55's family, doctor, and hospice company were contacted about the incident. The DON said all staff should know that if they were not a nurse they leave them there and get a nurse. The DON said the nurse has to complete an assessment before being moved because it could cause further harm. The DON said LA Z told her that he did not know to do that at the time. The DON said CNA Y's train of thought was that since Resident #55 was already up in her wheelchair she needed to get her to the nurse. The DON said she did tell CNA Y that she should have left Resident #55 in the area of where she fell and not moved her. The DON said staff were trained on what to do when a resident had a fall but she was not sure if the training was provided to non-direct care staff. The DON said she saw the importance from what happened today to change that because non-direct care staff do not need to be picking up residents from the floor after a fall. The DON said each department head was responsible for ensuring their employees were trained on different topics. The DON said she expected staff to wait for a nurse to come and assess the resident and not move them at all or from the area. The DON said if the resident was moved prior to a nurse's assessment that could cause further injury. The DON said she was ultimately responsible for ensuring residents were not moved prior to being assessed by a nurse after a fall. Interview on 11/12/24 at 2:05 PM with the HK Supervisor revealed LA Z told him he saw Resident #55 on the floor and since she was bleeding so he picked her up. The HK Supervisor told LA Z he was not supposed to do that and instead was supposed to wait for a nurse. The HK Supervisor said he was responsible for providing trainings to his staff on different topics. The HK Supervisor said he thought he had trained LA Z on what to do when a resident fell but he was not sure. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/12/24 at 2:15 PM with the Administrator revealed he found out that LA Z assisted Resident #55 in getting back to her wheelchair after she fell . The Administrator said CNA Y took Resident #55 in her wheelchair from the area where she fell to the nurse's station. The Administrator said Resident #55 had some bruising and a laceration to her forehead, but she was stable and acting as herself. The Administrator said LA Z should not have picked Resident #55 up from the ground, that it was not right to do that if he was not certified or licensed to do so. The Administrator said he was unsure if LA Z had been trained on what to do when a resident had a fall. The Administrator said all staff should know to never pick up a resident before a nurse completes an assessment. The Administrator said he ideally hoped what staff would do even if they were not trained was to notify a certified person like a nurse before moving them in anyway. Interview on 11/12/24 at 2:29 PM with HR revealed she was only responsible for orientation trainings that covered fall prevention when someone was newly hired. HR explained that department heads or the nursing department was responsible for any additional trainings for their staff. Interview on the phone on 11/12/24 at 5:16 PM with Resident #55's family member revealed there was a language barrier, but they were aware she had a fall and that she was okay. Interview on the phone on 11/12/24 at 5:18 PM with Physician V revealed he was unsure if the facility had communicated with him about Resident #55's fall and would have to confirm with his NP and office staff first. The surveyor never received any follow-up phone calls. Interview on the phone on 11/12/24 at 5:28 PM with Resident #55's Hospice company revealed a message was left for the Case Manager to call back at a later time with the information being requested. Record review of LA Z's personnel file reflected he was trained regarding fall prevention on 08/02/24, which did not include information on what to do after a resident has already fallen. Record review of the facility's Falls and Fall Risk, Managing policy, revised 11/14/23, reflected the following: According to the MDS, a fall is defined as: Unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force (e.g., a resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. Record review of the facility's undated policy titled Falls- Clinical Protocol reflected the following: .2. In addition, the nurse shall assess and document/report the following as needed 2. Record review of Resident #10 's quarterly MDS assessment, dated 10/17/24, reflected the resident was a [AGE] year-old female admitted to the facility initially on 05/01/20 and readmitted on [DATE], with diagnoses that included pressure ulcers/injuries, had a BIMS score of 11 indicating the resident's cognition was moderately impaired. It also reflected the resident had pressure ulcers/injuries, and she was at risk of developing pressure. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Ridgmar Medical Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE: 6600 Lands End Court Fort Worth, TX 76116	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #10's care plan, dated 10/11/24, reflected Resident #10 had a pressure ulcer to the left buttocks, left ischium, and arterial wounds to the right heel, left leg and left heel and abrasion to right leg and hip. Goals: The resident's Pressure ulcer will show signs of healing and remain free from infection. interventions were to administer treatments as ordered and monitor for effectiveness. Record review of Resident #10's physician's orders, dated 10/17/24, reflected the resident had an Arterial Wound to left heel and left leg, clean wound with wound cleanser or Normal saline, then pat dry, lightly pack with dakin soaked gauze to wound, then cover with dry dressing daily and as needed. Resident #10 had other orders dated 10/17/24 Cleanse right ischium abrasion with wound cleanser, pat dry, paint with betadine then calcium alginate, cover bordered gauze daily and as needed. Record review of Resident #10's November MAR on 11/14/24 reflected the last time wound care was performed was on 11/13/24 for his left heel, left leg and right ischium. Observation and interview with Resident# 10 on 11/12/24 at 03:29 PM revealed she had arterial wounds on her bilateral heels and on her bottom. Resident #10 stated she received wound care every day. Observation on 11/14/24 at 12:59 PM with the Wound Care Nurse revealed Resident#10 had a dressing on the right ischium, left heel and left leg that was clean and was not dated. Interview on 11/14/24 at 1:01 PM with the Wound Care Nurse revealed she was the one who had performed wound care on Resident #10 on 11/13/24 and she dated the sacrum and the left ischium. She stated for the other dressings on the resident's left heels, left leg and right ischium she did not know what happened; she forgot to put the date and initials on 11/13/24. She stated failure to put the date could cause the resident to miss the dressing change. Interview on 11/14/24 at 4:18 PM with the DON revealed her expectation was that nurses put dates on wound dressings for monitoring and ensuring the dressing changes were being done. The DON stated failure to date the dressing would hinder staff from ensuring dressing changes were done timely leading to wounds worsening. The DON stated the Wound Care Nurse was new in that position, but she had received training by a nurse from another facility. She stated she had not done an in-service on wound care with staff. Record review of the facility's current Wound Care policy, revised November 2017, reflected: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation: 1. Verify that there is a physician's order for this procedure . .12.Dress wound. Pick up sponge and apply directly to area. [NAME] tape with initial, time and date and apply to dressing .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 3 residents (Resident #42) reviewed for pressure ulcers. The facility failed to ensure Resident #42 received wound care treatment and services for newly identified wound to the sacral area. This failure could affect the residents, who received pressure ulcer care, by placing them at risk of infections and worsening of pressure ulcers. Findings included: Record review of Resident #42's face sheet dated 11/14/24 reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #42's Quarterly MDS Assessment, dated 11/02/24, revealed a BIMS score was not completed due to resident is rarely/never understood. Resident #42 had active diagnoses of malnutrition, muscle wasting and atrophy, abnormal posture, rheumatoid arthritis, hypertension, Dementia, and chronic kidney disease. MDS further indicated Section M - Skin Conditions revealed resident at risk of pressure ulcers/injuries. Resident #42 had no venous and arterial ulcers present. Record review of Resident #42's Care Plan, revised 10/11/24, reflected: Focus: The resident has pressure ulcer or potential for pressure ulcer development r/t Immobility. History of Stage 3 to Right Heel - resolved. History of Stage 3 to the rt buttock - resolved. Goal: The resident's will Pressure ulcer will show signs of healing and remain free from infection by/through review date. Interventions: Low air loss mattress in place. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. Goal: Resident at risk for pressure sores r/t Hx of ulcers. Goal: The resident will have intact skin, free of redness, blisters, or discoloration by/through review date. Interventions: air mattress to help with not developing new sores. Inform the resident/family/caregivers of any new area of skin breakdown. Monitor nutritional status. Serve diet as ordered, monitor intake and record. Record review of Resident #42's Weekly Body assessment completed on 11/06/24 reflected the resident had no skin issues. Record review of Resident #42's progress notes from 11/09/24 reflected: Cleansed wound to coccyx area with NS, pat dry, applied Maxsorb ll, covered with island dressing. Record review of Resident #42's physician orders reflected there were no treatment orders for wounds. Observation on 11/12/24 at 11:53 AM of Resident #42 revealed she was in bed sleeping, and the resident had an air mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/13/24 at 3:35 PM with the Wound Care Nurse revealed Resident #42 had no current wounds. She stated Resident #42 had a wound on the coccyx that had resolved in late August 2024. Interview on 11/14/24 at 1:37 PM with CNA W revealed she was the CNA assigned for Resident #42. She stated Resident #42 had a wound on her sacral area. She stated the resident had a dressing on with a date of 11/10/24. She stated either Saturday 11/09/24 or Sunday 11/10/24 it was noted Resident #42 had some redness to her sacral area. She stated the wound was reported to LVN TT. CNA W stated the dressing was cleaned and intact. She stated since it was reported to LVN TT, she thought everyone else knew about the wound. She stated she had not followed-up with anyone after 11/10/24 because she thought everyone knew about it. Interview on 11/14/24 at 1:41 PM with LVN TT revealed she was the weekend nurse for Resident #42 for the weekend of 11/09/24 and 11/10/24. She stated she could not recall if it was Saturday or Sunday, but the CNA on the hall reported to her that Resident #42 had redness to her sacral area. She stated she notified the Nurse Practitioner and was provided with an order to cleanse with normal saline and cover with a dressing. She stated Resident #42 had a history of ulcers. She stated she did not take any measurements; however, by her observation it was small and appeared to be less than 2 cm. She stated there was no drainage, no bleeding, and no signs of infection. She stated it was beginning to open, more of shearing of the skin. She stated she documented in the resident progress notes, 24-hour report and notified the Wound Care Nurse. She stated believed she generated the orders in the resident's clinical record. Observation on 11/14/24 at 2:30 PM with the Wound Care Nurse revealed Resident #42 was lying in bed sleeping. The Wound Care Nurse completed a skin assessment, and Resident #42's heels and other parts the body were intact. Resident #42 was observed to have a dressing on her sacral area dated 11/10/24. The dressing was clean and intact. The Wound Care Nurse removed the dressing, and the resident had a wound on the sacral area that was opening and had a scab. The measurements were 1 cm x 1.5 cm and 2x1 cm. There was scanty drainage with no redness or signs of infection noted. Interview on 11/14/24 at 2:40 PM with the Wound Care Nurse revealed she was unaware of the wound. She stated it had not been reported to her. She stated she was made aware of the wound today (11/14/24) when the skin assessment was completed. The Wound Care Nurse stated she would follow-up with the doctor and obtain orders. She stated she did not receive any information from the weekend nurse. She stated she reviewed the 24-hour report and did not see anything on Resident #42. The Wound Care Nurse stated she could not locate any treatment orders in the resident's chart. Interview on 11/14/24 at 2:58 PM with the NP revealed she was notified of Resident #42's sacral wound. She stated she visited the resident on Sunday 11/10/24 and observed the wound. She stated she staged the pressure ulcer on Resident #42's coccyx at a Stage 2. She stated she provided an order to apply Maxsorb. She stated her expectations were for the nursing staff to notify her immediately when they noticed a wound. She stated if treatment was delayed it could lead to worsening of the wound and infection. Interview on 11/24/24 at 3:11 PM with CNA UU by phone revealed she was the assigned CNA to Resident #42 for Saturday 11/09/24 from 2:00 PM-10:00 PM. She stated while providing incontinent care she noticed redness to resident sacral area; she stated it was not open and no drainage was noted. She stated it was only red, and it was less than a dime size. She stated she reported to LVN TT who was the assigned nurse on the hall and a dressing was placed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Ridgmar Medical Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 6600 Lands End Court Fort Worth, TX 76116	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's 24 Hour Report/Change of Condition Report dated 11/09/24 reflected: Resident #42 - Shearing (loose) wound to coccyx dressed. Record review of facility 24 Hour Report/Change of Condition Report dated 11/10/24 reflected: [Resident #42] -wound to coccyx - dressing intact - wound care department aware. Follow-up interview on 11/14/24 at 4:33 PM with the Wound Care Nurse revealed she did not review the 24-hour report in paper form. She stated she reviewed the 24-hour report in PCC, and it did not address Resident #42. She stated she normally did review both forms of communication, but she just forgot to review the 24-hour report paper form. She stated she contacted LVN TT. and it was reported that LVN TT had notified the NP and obtained orders. She stated LVN TT told her that she documented in the progress notes; however, LVN TT did not generate the order in the system. She stated all nurses could generate orders in the system. She stated the risk of not providing treatment to the resident was that it could lead to an infection. Interview on 11/14/24 at 4:45 PM with the DON revealed when a new wound was noted on a resident her expectations were for the charge nurse to contact the doctor, get orders, and start the treatment. She stated LVN TT did the correct thing by contacting the NP, obtaining orders, and documenting in the notes in PCC. She stated LVN TT documented in the 24-hour report and noted she had notified the Wound Care Nurse. However, the Wound Care Nurse stated she was not made aware of the wound. The DON stated the orders should be generated in PCC, if not, it would not be communicated within the nurses. She stated 24-hour reports were reviewed every morning during morning meeting. She stated Resident #42 report note was not picked up on. She stated the potential risk to the resident if treatment was not provided could lead to a decline of the wound. She stated she was glad LVN TT notified the NP and obtained order. She stated LVN TT was certain she generated the orders in PCC. Record review of Resident #42's Weekly Body Assessment completed on 11/14/24 reflected the following: New Skin Concern - Right buttock 2cm x 1cm treatment stated - Left buttock 1.5cm x 1cm treatment started. Record review of the facility's current Wound Care policy, revised November 2017, reflected: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation: 1. Verify that there is a physician's order for this procedure . .12.Dress wound. Pick up sponge and apply directly to area. [NAME] tape with initial, time and date and apply to dressing . The following information should be recorded in the resident's medical records: 1. The type of wound care given. 44140

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F 0693

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 32227

Based on observation, interview, and record review, the facility failed to ensure a resident who was fed by enteral means received appropriate treatment and services to prevent complications for 2 of 3 reviewed (Resident #44 and #84) for feeding tubes.

1. RN E failed to provide Resident #44 with two cartons of formula during bolus feeding as ordered by the physician.

2. The facility failed to follow physician's orders of providing Resident #84 with her 20 hours of feeding intake.

This failure could place residents at risk for a decline in health or adverse effects due to inappropriate management of g-tube care or weight loss.

Findings included:

1. Record review of Resident #44's quarterly MDS dated [DATE] reflected the resident was an [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included stroke, non-Alzheimer's dementia, dysphagia (difficulty swallowing), and cognitive communication deficit. The MDS further reflected the resident required a feeding tube for nutrition.

Record review of Resident #44's care plan revised on 09/23/24 reflected the resident had a potential/actual nutritional problem related to gastrostomy status - use a parenteral feeding as nutritional approach. Interventions included to provide and serve diet as ordered.

Record review of Resident #44's order summary report for November 2024 reflected the following :

Enteral Feed Order three times a day for nutritional enteral: Enteral Nutrition via Bolus: Isosource 1.5, 2 Cartons (500mL) TID. Provides 1500 mL, 2250 kcal, 102 g protein

Observation on 11/14/24 at 11:29 AM revealed that during the bolus feeding RN E performed hand hygiene and donned the appropriate PPE and only administered 1 carton of formula instead of 2 to Resident #44.

Interview on 11/14/24 at 12:35 PM with RN E revealed she had just started working at the facility two weeks prior and began caring for Resident #44 on Monday, 11/11/24. She said she misread the resident's orders and had only been given him 1 carton of formula for the past 3 days for breakfast and lunch. RN E said risk of not giving Resident #44 the correct amount of bolus formula could cause the resident not to get all of his nutrition.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/14/24 at 3:43 PM with the DON revealed she was not aware RN E had only been giving Resident #44 1 carton of formula instead of 2. The DON said the resident had a recent weight loss but it was related to him being in the hospital for 18 days of the prior month because he was having issues with this gtube placement. The DON further stated Resident #44 ran the risk of not getting his entire nutrition and less calories if he was not given 2 cartons of formula. Interview on 11/14/24 with the Dietitian revealed Resident #44's recent weight loss was related to his extended stay in the hospital. She said Resident #44 had recently has an 8 ounce weight gain since he returned from the hospital on 11/01/24 and that was a normal amount of gain for his body weight. The Dietitian further stated Resident #44 ran the risk of not getting all of his required nutrition if he was only getting 1 carton instead of 2 cartons of formula during his bolus feedings. Record review of Resident #84 's quarterly MDS assessment, dated 10/11/24, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included dysphagia (difficulty swallowing). The MDS assessment reflected the staff assessment for mental status was completed and indicated there was severe impairment cognitively. Record review of Resident #84's physician's orders reflected: Enteral Feed every shift Enteral: Enteral Nutrition Glucerna 1.2 at 85 ml per hour for 20 hours via pump. Start infusion at 11 AM and continue until 7 AM. with a start date of 10/07/24. Record review of Resident #84's care plan, dated 07/13/24, reflected: Focus: [Resident #84] requires the use of a feeding tube rule out dysphagia;Goal: Resident will maintain adequate nutritional and hydration status as evidenced by weight being stable, no signs or symptoms of malnutrition, or dehydration through review date; Interventions: Administer tube feeding and water flushes as ordered. 2. Observation on 11/12/24 at 12:57 PM of Resident #84 revealed her tube feeding machine was not on. The tube and the pole were splashed with feeding residues, and she was not able to answer any questions. Observation on 11/13/24 at 12:16 PM of Resident #84 revealed her tube feeding machine was not on and she was not able to answer any questions. Observation and interview on 11/13/24 at 12:51 PM with LVN O revealed she was Resident #84's nurse. She stated she took over the hall at 11:00 AM and she stated she does not know who put on the pump. She stated she knows the machine get turned off in the morning at 7:00 AM. LVN O said she knew Resident #=84's tube feeding machine was supposed to be turned back on at 11:00 AM but she thought the other nurse turned it on before she left. She stated the same thing happened on 11/12/24 and the machine was put on the same time as today. LVN O said Resident #84's order stated she was supposed to receive 20 hours of nutrition and the machine should only be off for four hours. LVN O said not turning the machine on when it was time would have caused Resident #84 not to get her full 20 hours of nutrition and it would put her at risk of losing weight. Observation and interview on 11/13/24 at 02:38 PM with LVN SS revealed she was Resident #84's nurse from 6:00 AM-11:00 AM. She stated she disconnected the pump machine at 07:00AM and Resident #84 was supposed to be connected back at 11:00 AM. She stated when she gave report the resident was not connected, the oncoming nurse was supposed to connect her back. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/14/24 at 12:10 PM of Resident #84 revealed her tube feeding machine was not on and she was not able to answer any questions. Interview with the DON on 11/14/24 at 12:15 PM revealed her expectation was, staff should follow the doctors' orders a to any resident's down time for their tube feeding machine and nutrition. The DON said she need to figure out why it happened today again, and she had talked to nurses the previous day but she stated she had brand new nurses working on that hall form 11:00 AM.The DON said the purpose of following the order was to make sure the resident got the proper amount of calories for sustainability and if not, it put them at risk of losing weight. She stated the nurses were supposed to notify the doctor and get a new order to compensate for the hours missed. She stated she called the doctor, and they will adjust the time. She stated she does not think she has done training on g-tube feeding but facility had done competency skills with staffs. She stated she expected the nurses to keep the pole and the pump clean. Observation and interview on 11/14/24 at 12:33 PM with LVN P revealed she was Resident #84's nurse. She stated she took over the hall at 10:00 AM and she was falling behind. She stated she had just connected Resident #84 pump machine. She stated she called the nurse practitioner, and she got new orders to connect the pump at 12:30 PM because they were falling behind, and she did not want that to happen in future. She stated the potential risk wound resident getting hungry and no other risks. Record review of the facility's current Enteral Nutrition policy, revised November 2018, reflected: .11. The nurse confirms that orders for enteral nutrition are complete. Complete orders include: .f. The volume /rate goals and recommendations for advancement toward these: and g. Instructions for flushing (solution, volume, frequency, timing and 24-hour volume) . Record review of the facility's Enteral Tube Feeding via Syringe (Bolus) policy, revised July 2019, reflected the following: Purpose The purpose of this procedure is to provide nutritional support to residents unable to obtain nourishment orally .General Guidelines .2. Check the enteral nutrition label against the order before administration 42859

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident for 1 of 3 residents (Resident #84) reviewed for pharmaceutical services. LVN O failed to follow physician orders for administering a Scopolamine Transdermal Patch, which was used to prevent nausea and vomiting, to Resident #84 on 11/12/24. This failure could put residents at risk of not receiving their medications as ordered. Findings included: Record review of Resident #84 's quarterly MDS assessment, dated 10/11/24, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included Myopathy (general term referring to any disease that affects the muscles that control voluntary movement in the body)and Dementia (general term for a decline in mental abilities that affects a person's daily life).The MDS indicated resident had severely impaired cognition. Record review of Resident #84's November 2024 Physician Orders dated 3/23/2024 reflected the following: Scopolamine Transdermal Patch 72 Hour (Scopolamine). Apply 1 patch transdermal every 72 hours. Observation on 11/14/24 at 10:00 AM with the DON, revealed Resident #84 was having 2 Scopolamine Transdermal patches on the right ear dated 11/9 /24 and 11/12/24.Resident skin was intact. Telephone interview with LVN O on 11/14/24 at 2:59 PM revealed she was the one that applied the patch dated 11/12/24 on Resident #84, she stated she did not see the patch dated 11/09/24. LVN O stated she was aware she was supposed to remove the old patch before administering the new one. She stated the risk of not removing the old patch was over medication and skin irritation. LVN O stated she had done in services on medication administration. Interview with the DON on 11/14/24 at 4:24 PM revealed her expectation was that nurses should remove the old patch before applying the new patch. She stated failure to remove the old patch would lead to overdose. She stated facility had done in-service on medication administration on but not on patches removal. No dated training was provided. Record review of the facility trainings revealed LVN O had skill checks but no date on the training. Record review of the facility's current Pharmacy Services policy, dated April 2007, reflected the policy did not address patch administration and removal. The DON stated they did not have a policy that addressed patch removal.

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F 0758

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44140

Based on interview and record review, the facility failed to ensure any drug regimen irregularities reported by the Pharmacist Consultant were acted upon, for 1 of 5 residents (Resident #80) reviewed for unnecessary medications, psychotropic medications, and medication regimen review.

The facility's Pharmacist Consultant recommended a dose reduction for Resident #80's Olanzapine 10mg. The physician agreed to be reduced to 5 mg, but the medication continued to be administered at 10 mg to the resident.

This failure could place residents on psychoactive medications at risk for possible adverse side effects, adverse consequences, and decreased quality of life.

Findings included:

Record review of Resident #80's face sheet dated 11/14/24 reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE].

Record review of Resident #80's Quarterly MDS Assessment, dated 10/14/24, revealed a BIMS score of 14, which indicated his cognition was intact. The MDS further revealed he had an active diagnoses of heart failure, hypertension, unspecified dementia, schizophrenia disorder and bipolar disorder.

Record review of Resident #80's undated Care Plan reflected Focus: The resident uses psychotropic medications r/t Bipolar, mood disorder, Schizoaffective. Interventions: Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT.

Record review of Resident #80's physician order dated 10/03/23 revealed OLANZapine Oral Tablet 10 MG (Olanzapine) Give 1 tablet by mouth one time a day related to BIPOLAR DISORDER, CURRENT EPISODE MANIC WITHOUT PSYCHOTIC FEATURES, UNSPECIFIED D/C date 10/08/24.

Record review of Resident #80's Pharmaceutical Consultant Report Psychoactive Gradual Dose Reduction dated 01/18/24 revealed the following:

According to Long-term care Drug Monitoring Regulations, our review of the above patient's chart identifies the following as requiring [your] attention. Please evaluate the routine use of the following psychoactive medication and consider a dose reduction. If a reduction is not desired, please indicate below a rationale for the continued use. This resident is prescribed the following psychoactive medications:

- Olanzapine 10mg QHS - Trazodone 50mg QHS

Physician Response to Record review: A dose reduction is appropriate: Yes - if yes, new order - Olanzapine to 5mg QHS. Signed by Physician on 01/25/24.

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #80's Medication Administration Record reflected he was taking Olanzapine 10 mg by mouth one time a day for bipolar disorder. The MAR further reflected Resident #80 was administered the medication from 01/25/24 through 07/05/24. Interview on 11/12/24 at 12:03 PM of Resident #80s revealed he was doing well. Resident #80 stated he believed he received all his medications. He stated he could not recall what medications he was on. Interview on 11/14/24 at 3:34 PM with the DON revealed she was responsible for reviewing pharmacy recommendations. She stated she could confirm she had completed all pharmacy recommendations. She stated she was trying to locate why Resident #80's pharmacist recommendation was not completed. She stated the resident psychiatrist might had not agreed to the dose reduction; however, there was no documentation. She stated she was waiting on the resident psychiatrist to return her call. The DON stated in this case there was no risk to the resident for adverse reaction. Follow-up interview on 11/14/24 at 4:43 PM with the DON revealed she could not locate any documentation on to why Resident #80's Olazapine medication was not reduced. She stated the Psychiatrist contacted her and stated she was unaware of the pharmacist and physician recommendation. She stated it was a mistake on her part. She stated another GDR was completed in July 2024 for Resident #80 Olanzapine 10mg medication and dosage did not change. The DON stated it was important to follow pharmacy recommendations; however, if psych had any concerns regarding the medication psych would have had changed it. Record review of the facility's Tapering Medications and Gradual Drug Dose Reduction: policy, revised April 2007, reflected the following: Residents who use antipsychotic drugs shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on observation, interview, and record review, the facility failed to ensure that the menu was followed for the lunch meal on 11/13/24 for 1 of 2 reviewed (Resident #11) for food and nutrition services. The facility failed to ensure residents on a pureed diet were served pureed bread during the lunch meal on 11/13/24. This failure could place residents at risk for unwanted weight loss, hunger, unwanted weight gain, and metabolic imbalances. Findings included: Record review of Resident #11's face Sheet, dated 11/13/24, reflected the resident was a [AGE] year-old female who was initially admitted on [DATE] and readmitted on [DATE]. Record review of Resident #11's undated consolidated physician's orders reflected the resident had an active order for a regular/enhanced diet, pureed texture, nectar thick consistency starting on 10/28/24. Record review of Resident #11's MDS, dated [DATE], reflected primary diagnoses of congestive heart failure, dysphagia, muscle wasting, malnutrition, and renal insufficiency. Resident also had a BIMS score of 11. Further review reflected Resident #11 required a mechanically altered therapeutic diet. Record review of Resident #11's undated care plan reflected, Focus: The resident has potential nutritional problem, pureed diet, NTL. Uses divider plate. Goal: The resident will maintain adequate nutritional status as evidenced by maintaining weight within 5% of her BASELINE, no s/sx of malnutrition, through review date. Interventions: Monitor/document/report PRN any s/sx of dysphagia: pocketing, chocking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concern during meals. Monitor/record report to MD PRN s/sx of malnutrition: Emaciation (Cachexia) muscle wasting, significant weight loss: 3 lbs in 1 week, >5% in 1 month, >7% in 3 months, >10 % in 6 months. Provide and serve diet as ordered. **PUREED****NECTAR LIQUIDS**. Provide, serve diet as ordered. Monitor intake and record q meal. RD to evaluate and make diet change recommendations PRN. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Administer medications as ordered. Monitor/Document for side effects and effectiveness. Record review of Order Listing Report dated 11/14/24 reflected the facility had eight total residents on a pureed diet. Record review of the facility's menu for the lunch meal on 11/13/24 revealed country fried steak with cream gravy, garlic mashed potatoes, buttered carrots, warm roll, chocolate Oreo pudding, and beverage. (continued on next page)

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/13/24 at 11:10 AM revealed that [NAME] RR did not puree rolls for the facility's lunch meal. Observation on 11/13/24 at 12:45 PM revealed the pureed test tray provided to survey team did not have a pureed roll. The regular test provided to survey team did have a roll. Observation on 11/13/24 at 1:23 PM revealed that Resident #11 did not receive pureed bread on her lunch plate. Interview on 11/13/24 at 1:45 PM with [NAME] RR revealed that he forgot to puree the dinner roll. [NAME] RR was unable to answer further questions about pureed meals. Interview on 11/13/24 at 1:50 PM with the Dietary Manager, who had been employed at the facility for two days, revealed that the facility policy stated that regular, puree, and mechanical soft diets were all supposed to receive the same items on the menu but in different forms (textures). The Dietary manager stated that this was important so that residents on pureed and mechanical soft diets do not experience negative mental and effects from eating different foods from residents with regular diets. The Dietary Manager added that it was important also so that the residents did not experience any negative health effects due to a lack of nutrition. The Dietary Manager said that he would be in-servicing his staff on nutrition value as well as the risk of residents not receiving all items listed on the menu. The dietary manager stated that he would be putting systems in place to ensure this did not occur in the future. Interview on 11/13/24 at 1:54 PM with the Dietician revealed that the policy stated that dietary staff were to follow the diet menu spreadsheet provided by the food service products distributer. She stated that the importance was because it was nutritionally designed to meet residents' needs. If all the items were not prepared that were on the spreadsheet, then the resident can have a negative clinical outcome. The Dietician stated that she last in-serviced on 10/25/24 on following menus and diet textures. Record review of the facility's Menus policy, revised October 2008, reflected the follow: Menus shall a) meet the nutritional needs of residents; b) be prepared in advance; and c) be followed.