STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675739	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood at the Woodlands	10450 Gosling Rd The Woodlands, TX 77381

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 of 12 residents (Resident #43) reviewed for rights and dignity. - The facility failed to ensure that nursing staff used privacy curtain between the hallway door and the resident, removing resident from public view and prevent exposure of body parts while providing peri care to Resident #43. - The facility failed to ensure that the nursing staff used the privacy curtain between Resident #43 and Resident #45 while providing incontinence care to Resident #43, to prevent exposure of body parts. This failure could place residents at risk for loss of dignity, self-worth, and diminished quality of life. Record review of Resident #43's face sheet dated 06/11/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and originally admitted on [DATE]. The diagnoses included dementia, stroke, swallowing disorder, language disorder, arthritis, muscle weakness and delusional disorders. Record review of Resident #43's annual MDS dated [DATE] revealed a BIMS score of 3 out of 15 indicating severe cognitive impairment. She required substantial/maximal assistance with toileting, sit to stand: helper does more than half the effort; helper lifts or holds trunk or limbs and provides more than half the effort. Resident #43 was frequently incontinent of bowel and bladder. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675739	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood at the Woodlands	10450 Gosling Rd The Woodlands, TX 77381

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #43's undated care plan revealed: Focus- the resident had impaired cognitive function and impaired thought processes and may miss the intent when spoken to d/t Moderate Dementia with Behaviors. BIMS score of 5; Goal- will maintain current level of decision-making ability by review date. Target date 06/18/25. Interventions included - Communicate with the resident/family/caregivers regarding resident capabilities and needs. Cue, reorient and supervise as needed. Don't argue or correct me if I get confused to reality. Identify yourself at each interaction. The resident understands consistent, simple, directive sentences. Provide the resident with necessary cues-stop and return if agitated. Focus - Resident #43 has an ADL self-care performance deficit r/t Dementia and stroke. Interventions included - Provide the following assistance with ADLs in self-performance and staff support, Transfer - limited-total assist of 1; Toileting - limited-total assist of 1. Focus - Resident #43 is always incontinent of bladder and bowel and requires assistance AEB self-care deficit, confused, disoriented related to dementia disease process. Goal- promote dignity by keeping resident clean, dry, and free from odor every shift through the next review. Target date: 06/18/2025. Resident will not develop any complications associated with incontinence. Observation on 6/18/25 at 2:30 PM of the undated video footage #2 submitted by the RP revealed, CNA-E was performing incontinent care for Resident #43. The privacy curtain was not drawn between the resident and the closed door. The door was not opened during the time the resident was exposed. Observation on 6/18/25 at 2:30 PM of an undated video footage #6 submitted by the RP revealed two unidentified nursing staff performing incontinent care for Resident #43. The curtain between Resident #43 and Resident #45 was not drawn. Resident #45 was sitting next to Resident #43's bed during the incontinent care. The curtain was not drawn between Resident #43's bed and the door to the hallway. During incontinent care, one of the nursing staff partially opened the door and stood at the open door while Resident #43's pants were around her knees and thighs were exposed. Interview on 06/18/25 at 10:30 AM, Resident #43 did not remember any incidents. Telephone interview on 6/18/25 at 3:45 PM, Resident #43's RP stated there were some video footage with the curtain not being closed properly to ensure Resident #43 was not exposed. Interview on 06/20/2025 at 1:05 PM, the Administrator stated a meeting with the RP occurred after the reported incident and the RP shared video footage. The Administrator stated the RP flipped through the video quickly the Administrator was unable to view much of the detail. Interview on 6/20/25 at 2:00 PM the ADON stated she expected when providing incontinent care, the nursing staff should announce themselves, provide privacy by closing doors, pull curtains as much as possible. Interview on 6/20/25 at 2:05 PM, the Corporate Nurse stated she expected nursing staff to provide privacy during incontinent care by closing doors and closing blinds. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675739	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood at the Woodlands	10450 Gosling Rd The Woodlands, TX 77381

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility investigation report revealed on 5/31/25 the Administrator received a call from the weekend supervisor LVN-E about Resident #43. LVN-E was instructed to call the RP and ask to review the cameras and to send CNA-E home. RP reported customer service issues regarding the CNA. Further review of the facility investigation revealed on 06/02/25 the Administrator and the DON met with Resident #43's RP at 11:00 AM to discuss the care concerns from the previous weekend. The meeting lasted one hour and the discussion included the resident's plan of care, incontinent care and overall needs. Record review of the facility policy for Perineal Care, revised on 1/2024 read in part: .It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed .Policy Explanation and Compliance Guidelines .4. Inform resident on procedure to be performed .5. Provide privacy by pulling privacy curtain or closing room door if a private room . Record review of the facility policy for Promoting/maintaining Resident Dignity, revised on 1/2025 read in part: .it is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Compliance Guidelines: 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights 12. Maintain resident privacy .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675739	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood at the Woodlands	10450 Gosling Rd The Woodlands, TX 77381

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the resident had the right to be free from abuse for 3 of 4 residents (Resident #1, Resident #22 and Resident #43) reviewed for abuse. The facility failed to ensure Resident #1 was free from verbal abuse when CNA S yelled at her using a cuss word and asking what was wrong with her. The facility failed to ensure Resident #22 was free from verbal abuse when Medication Aide B used a racial slur towards her. The faciity failed to ensure Resident #43 was free from physical abuse when CNA A assisted with changing Resident #43's adult brief. These failures could place residents at risk of feelings of indignity, irritability, and sadness. The findings included: Resident #1 Record review of Resident #1's admission Record dated 5/22/25 revealed she was admitted to the facility on [DATE] with diagnoses of cerebral palsy (a condition that is caused by brain damage or abnormal development of the brain that affects movement and coordination), epilepsy (a neurological condition that causes recurrent seizures), anxiety disorder, dementia (a decline in memory or other thinking abilities that can interfere with daily life), aphasia (a communication disorder that impairs a person's ability to process and understand language), major depressive disorder and adjustment disorder (a mental health condition triggered by a stressful life event or change causing difficulty in coping and adapting). She was [AGE] years of age. Record review of Resident #1's Care Plan Report, undated, revealed the following focus areas, goals, and interventions: - Focus: (Resident #1) was at risk of impaired communication. Goal: Resident would be able to effectively communicate basic needs. Target date: 4/17/25. Interventions: allow adequate time for resident's responses, educate staff on anticipation of resident's needs until an alternate communication method can be established, incorporate alternate means of communication such as music, song or visual demonstration, incorporate visual prompting, cues or gestures, and provide clear, simple instructions. - (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675739	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood at the Woodlands	10450 Gosling Rd The Woodlands, TX 77381

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Focus: (Resident #1) had impaired communication including speech problems and tended to yell out related to expressive aphasia. Goal: Resident will be assisted with communication abilities. Target date: 4/17/25. Interventions: anticipate and meet needs, encourage resident to continue stating thoughts even if resident is having difficulty. Focus on a word or phrase that makes sense , or responds to the feeling resident is trying to express, validate resident's message by repeating aloud. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed her speech clarity was described as no speech- absence of spoken words. She was rarely/never understood and rarely/never understood others. She had severe cognitive impairment. She was dependent on others for all self-care tasks. Record review of a Provider Investigation Report dated 4/23/25 signed by the Administrator revealed on 4/21/25 at 2:30pm there was an allegation that CNA S, who was a contract worker, verbally abused Resident #1. Witnesses included Medication Aide E and a PASRR Provider. The section for Investigation Summary stated the following: Staff reports that a contract employee was speaking disrespectfully about (Resident #1) and overheard asking her 'What the F*** is wrong with you' while resident was hollering out. Staff immediately intervened and redirected the situation by escorting the staff member from the hallway into the administrator's office and assessing (Resident #1). CNA S was immediately terminated from the facility and the contracted staffing agency was notified. The facility confirmed the incident occurred. The resident was immediately assessed on 4/21/25 at 2:45pm with no signs of distress. Record review of a statement provided by CNA S dated 4/21/25 revealed she asked the Medication Aide why (Resident #1) was yelling. I wanted to know how she was communicating with me and what she was needing . I made a joke and said, is she just being an asshole? I was not in her room, I was down the hall. I did not say it to the resident or in front of the resident. In an observation on 5/20/25 at 1:32pm, Resident #1 was in her room sitting in her wheelchair. When surveyor spoke to her, she said the word fine multiple times loudly and shook her head up and down. In a telephone interview on 5/22/25 at 2:17pm, CNA S said on the day of the incident, she was scheduled to work the 2pm-10pm shift at the facility. She said she worked first at the facility a few months ago, then again in April 2025. She said she walked through the hall with the Medication Aide. She said she heard a patient yelling, and she had a hard time communicating. She said the resident was 3 doors down from where the medication aide was located on the hall. She said she did not yell at the resident. She said she asked the resident, What do you need? Do you need to change your brief? Do you need water? She said she approached the medication aide and wanted to know how she could communicate with her. She said she asked him if Resident #1 needed anything, or was she being an asshole? She said the comment she made was reported to the Administrator. When asked about abuse or neglect training, she said she was not trained beforehand. She said she had to acknowledge something on the agency's website when she selected the shift, but she tapped through it and did not properly read it. Record review of a statement provided by Medication Aide E dated 4/21/25 revealed CNA S asked him what to do and what residents she is taking care of. His statement noted, A little while later, she said 'what the F*** is she yelling about. Why is she being an asshole. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675739	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood at the Woodlands	10450 Gosling Rd The Woodlands, TX 77381

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 5/20/25 at 2:47pm, Medication Aide E said on the day of the incident, he was working on Resident #1's hall. He said when he arrived, he showed CNA S what to do, gave her a tour, and briefly described her assigned residents. He said a little while later when he was on the medication cart, he heard CNA S use very unprofessional language down the hall near Resident #1's room. He said the PASRR Provider was nearby, but he was not sure exactly what was said. He said she started talking to him using unprofessional language. He said the incident was immediately reported to the administrator. Record review of a statement provided by the PASRR Provider dated 4/22/25 revealed she overheard the CNA talking to Resident #1 stating, What the F*** is wrong with you, then states she overheard the CNA tell Medication Aide E, what is wrong with (Resident #1) or is she just being an a******. In a telephone interview on 5/22/25 at 10:35am, the PASRR Provider said on the day of the incident, she was two rooms down from Resident #1's room with another resident. She said Resident #1 was usually very loud, and on this day she was being herself. She said she heard a staff member say, What the hell is wrong with you. Shut the F*** up. She said she got up and walked down to Resident #1's room and saw CNA S with Resident #1. She said she asked Resident #1 if she was okay, and she started laughing. She said CNA S looked her up and down. She said they left the room, and Medication Aide E was on a cart nearby. She said she heard CNA S tell the medication aide, Can I ask you a question? What is wrong with her, is she just being an asshole? She said when CNA S left, she told Medication Aide E that Resident #1 could not communicate, and it was reported to the administrator right away. When asked if the interaction between CNA S and Resident #1 was considered verbal abuse, she said yes. Record review of Resident #1's Behavioral Health Diagnostic assessment dated [DATE] revealed she was referred to psychology services due to a recent staff incident. The assessment described using a patient language flip chart to assess mood and clinical concerns. Patient indicated being 'happy' several times . When asked how she was doing she reported being 'fine' and frequently smiled at the clinician . it appears with prompting and assistance (or by yelling out) (patient) is able to make needs known. The assessment was signed by the Licensed Psychologist. In an interview and record review on 5/22/25 at 11:30am, the Administrator said when an agency CNA scheduled a shift at the facility, they had to complete abuse and neglect training and review facility expectations before they scheduled a shift. The Administrator reviewed the agency's website and found CNA S' acknowledgement. Record review of the acknowledge revealed it was dated 4/21/25 at 7:39am. Resident #22 Record review of Resident #22's admission Record dated 5/21/25 revealed she was admitted to the facility on [DATE] with diagnoses of cerebrovascular disease (a group of conditions that affect the blood vessels and blood supply to the brain), morbid obesity, dementia with agitation, contractures of the left and right hand and left and right lower legs (a condition of shortening and hardening of the muscles, often leading to deformity and rigidity of joints), bipolar disorder (a mental health condition characterized by extreme mood swings), anxiety disorder, major depressive disorder and history of transient ischemic attack (a temporary disruption of blood flow to the brain). She was [AGE] years of age. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675739	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood at the Woodlands	10450 Gosling Rd The Woodlands, TX 77381

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #22's Care Plan Report, undated, revealed the following focus areas, goals and interventions: - Focus: Resident #22 had periods of inattention and delirium related to disorganized thinking. Goal: Resident would be free of symptoms of delirium including changes in behavior, mood, cognitive function and communication. Target Date: 12/23/24. Interventions: Educate the caregivers to observe for and report any signs and symptoms of delirium, encourage the resident's caregivers to be at bedside during acute episodes in order to provide familiarity and support and engage the resident in simples, structured activities that avoid overly demanding tasks. - Focus: Resident #22 had impaired cognitive function and impaired thought processes related to dementia. Goal: Resident's needs would be met and dignity would be maintained, and the resident would be able to communicate basic needs on a daily basis. Target Date: 12/23/24. Interventions: Ask yes/no questions in order to determine the resident's needs, cue, reorient and supervise as needed, identify yourself at each interaction, keep the resident's routine consistent, try to provide consistent caregivers as much as possible in order to decrease confusion, monitor and report any changes in cognitive function, and present just one thought, idea, question or command at a time. - Focus: Resident #22 had unwanted behaviors related to cursing at staff, made false accusations at staff, and could be racist and called staff names at times. Goal: The resident would have fewer episodes of racial slurs one time a week. Target date: 12/23/24. Interventions: Anticipate and meet the resident's needs, caregivers to provide opportunity for positive interaction and attention, explain all procedures to the resident before starting and allow the resident time to adjust to changes, give 1:1 assistance to try and calm resident down as needed, discuss the resident's behavior and explain why behavior is inappropriate, monitor behavior episode and attempt to determine underlying cause and praise any indication of the resident's progress/improvement in behavior. Record review of Resident #22's quarterly MDS assessment dated [DATE] revealed she had a BIMS of 12, indicating she had moderate cognitive impairment. She had a PHQ-9 score of 7, indicating mild depression. She was dependent on others for all self-care tasks except for eating, when she required partial/moderate assistance of others. Record review of a Provider Investigation Report dated 10/31/24 signed by the Former Administrator revealed Resident #22 told an employee of psychology services that a facility staff member, Medication Aide B, called her white trash. The Former Administrator interviewed the resident, and she said the staff was in the hallway and said white trash. She could not recall the date it occurred. Resident #1 was assessed by psychology services on 10/30/24. The section for Provider Response stated, Staff was removed from 10/30/24 shift pending investigation. Abuse/neglect in-service was initiated. Witness agency CNA for hospice says that the staff of facility (Medication Aide B) did not state what patient said. Witness states resident is not giving a truthful encounter. Agency staff states she would have reported staff if the staff abused resident, but staff did not. The investigation findings were unfounded. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675739	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood at the Woodlands	10450 Gosling Rd The Woodlands, TX 77381

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Former Administrator's attached Investigation Summary dated 10/31/24 revealed she was notified on 10/30/24 at 2pm by a contract psychology services staff member that Resident #22 made an allegation of abuse. She interviewed Resident #22 and she said the staff called her white trash yesterday (the administrator's statement did not indicate who the staff member was), and stated she apologized for calling staff names. At 10/30/24 at 2:30pm, the Former Administrator interviewed the staff that the resident made the allegation about, Medication Aide B. Medication Aide B reported on the evening of 10/29/24, she noticed the hospice aide was assisting Resident #22 with the door open, and she closed the door. The Former Administrator interviewed the hospice aide and the nurse who worked the evening shift with no significant findings. The facility staff interviewed random staff who worked on Resident #22's hallway and found they were not aware of abuse or neglect and could state the abuse/neglect policy and procedures. The Former Administrator concluded, no abuse or neglect occurred. The resident has history of calling staff racial slurs/names (the N-word). The staff in question is African American and has admitted this resident has called her (the N-word) on several occasions. She stated she doesn't enter the resident's room and she is always assigned to another staff member because of the disrespect by resident towards her. When resident has been asked why she speaks this way by (Former Administrator), she responds 'that's how I was raised.' . Patient's family/RP state they are aware of her behaviors and false allegations, and they do not believe anyone abuse patient (Resident #22). Employee was allowed to return to regular schedule. In an interview on 5/21/25 at 9:46am, Resident #22 said a few months ago, Medication Aide E was in her room talking with her. She said she told her something I did with men and thought she did it, too. I thought we could be friends. She said Medication Aide E then called her white trash. She said she felt insulted because of the comment. In an interview on 5/22/25 at 2:40pm, Medication Aide E, when asked about the comment she made, she said You mean right after she called me a (n-word)? I asked her to describe the incident. She said a few months ago, she had finished changing her brief or feeding her. She said Resident #22 asked her to change the TV channel, and she said she would after she put the tray down. She said then, Resident #22 called her the n-word. She said she told her, What if I called you white trash? How would you feel? She said after that, Resident #22 said she hurt her feelings. She said they have not had any interactions since then. She said she looked at Resident #22 as a friend since she was younger. I felt surprised, she hurt my feelings. If it was an older resident with dementia, it would have rolled off. Resident #43 Record review of Resident #43's face sheet dated June 11, 2025 revealed a [AGE] year-old female who initially admitted to the facility on [DATE] and re-admitted on [DATE] with a diagnosis of moderate dementia with behavioral disturbance, cerebral infarction (stroke), dysphagia (difficulty swallowing), chronic obstructive pulmonary disease, congestive heart failure, Poly osteoarthritis, hypertension (high blood pressure), amaurosis fugax (temporary loss of vision in one or both eyes), reduced mobility, repeated falls, abnormality of gait and mobility, and pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675739	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood at the Woodlands	10450 Gosling Rd The Woodlands, TX 77381

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #43 ' s Quarterly MDS (Minimum Data Set) dated 6/06/2025 revealed a BIMS Summary Score of 2 indicating severe cognitive impairment. Resident #43 ' s functional abilities revealed substantial/maximal assistance where the helper does more than half the effort for toileting hygiene, shower/bathe self, upper body dressing, lower body dressing putting on/taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfers and walking 10 feet was not attempted due to medical condition or safety concerns. Record review of Resident #43 ' s Care Plan dated 6/11/2025 revealed a self-care deficit for bathing, dressing, feeding with interventions to encourage resident to participate in planning day to day care, offer compassionate, empathic, ADL care to resident each day. Project a positive attitude when caring for the resident, provide assistance with ADL ' s as needed .Resident #43 required assistance to perform functional abilities in self-care and mobility with interventions to provide the following self-care assistance: .toilet hygiene, shower/bathe self, upper body dressing, roll left to right, sit to lying, lying to sitting on the side of the bed and with no back support, sit to stand, chair/bed-to-chair transfer, toilet transfer tub/shower required partial/moderate assistance and lower body dressing required substantial maximal assistance. Resident #43 had an ADL self-care performance deficit r/t dementia, and CVA with interventions to provide the following assistance with ADLs in self-performance and staff support for bed mobility with limited- total assist of 1 . transfer with limited- total assist of 1 and toileting with limited- total assist of 1. Resident #43 was at risk for falls and was at risk for increased falls and injury r/t gait/balance problems, poor communication/comprehension, poor safety awareness, psychoactive drug use with interventions to administer pain. Record review of Resident #43 ' s Bed Rails Evaluation assessment dated [DATE] revealed appropriate alternatives were attempted prior to considering bed rails and resident did not have bed rails at this time. Resident #43 was not able to state their preference, responsible party did not request bed rails, the level of consciousness did not fluctuate, but Resident #43 did display poor bed mobility or difficulty moving to a sitting position on the side of the bed, difficulty with balance or poor trunk control, but bed rails were not considered. Interview on 05/20/25 at 9:50AM with Resident #43, she stated that she could not remember A CNA pulling on her roughly or anything that allegedly happened. She stated that she did not remember the incident that took place. The resident does not require Dual help, she has risk of memory loss and delusion and is considered a fall risk, how she is ordered to maintain some areas of independence to aid in maintaining mental state of mind. Interview on 05/20/25 at 10:00 AM with Resident #43 ' s family member #1, she stated that Resident #43 was being assisted by the CNA A, when she heard her Resident #43 scream in what appeared to be pain. She stated that the camera was partially blocked but she could see some movement. She stated that she was unable to email the recordings. Observation and interview on 05/20/2025 at 10:30 AM with Resident# 43 ' s family member #2, revealed camera footage that shows resident #43 laying on the bed while CNA A was attempting to turn her on the bed to change resident #43. Observation revealed that on 04/09/25 7:09 Am Resident #43 was being changed by CNA A at which time CNA A pulled the chuck from under resident #43. The family stated that she saw the CNA pull the chuck from under the resident in a manner hard enough for Resident #43 to scream. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675739	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood at the Woodlands	10450 Gosling Rd The Woodlands, TX 77381

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/21/2025 at 10:45 AM with the Administrator, she stated that she self-reported the incident with Resident #43 where the CNA was assisting Resident #43 to change, and the former and contacted the family, about the incident that was reported to the agency. She stated she has never been abused and that the family never showed the provider any photos or video. Interview on 05/21/2025 at 12:34 PM with the CNA A, she stated that she worked with Resident #43 for one day. She stated that on 4/9/25 the day of the incident Resident #43 had feces on her and that she was moving the blanket that was under her to avoid her smearing or spreading bowel movement. A former staff member stated that she quit because she was upset that she was being blamed for mistreating Resident #43, when she was complaining that there were no wipes available to clean the resident. Interview on 05/20/25 at 9:15 Am with the Maintenance worker, he stated that the policy required that the beds, if reported that they slide or moving be placed on a TEL, a circular rubber stopper designed to stop the movement of wheels on the bed. Interview on 05/20/25 at 9:30 AM with the Administrator, she stated that it was discussed with the corporate office that the older beds had wheels and locks that were discontinued. She stated that because the locks were discontinued, it was determined that lock pads would be placed as needed on the base of the wheels. Record review of a One-on-One In-service Attendance Record dated 10/30/24 revealed Medication Aide B was in-serviced on abuse, neglect, policies and procedures and abuse coordinator. The in-service was provided by the Former Administrator. In an interview on 5/23/25 at 12:53pm, the Administrator stated the facility in-services staff on abuse and neglect at least once a month and emphasized it during new hire orientation. She said residents would be at risk of mental anguish and depression if they were verbally abused. She said after the incident that occurred with Resident #1, they removed CNA S from the hall, took statements, assessed Resident #1, referred her to psychology services, notified her physician, completed in-services, completed life safety interviews with residents and reported to the staffing agency. She said CNA S was onsite at the facility for about 30 minutes. Record review of the facility's Abuse Neglect and Exploitation Policy dated 1/8/23 and revised on 1/2025 read in part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse . 'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish which can include staff to resident abuse . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675739	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood at the Woodlands	10450 Gosling Rd The Woodlands, TX 77381

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 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** Based on observation, interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practices, the comprehensive care plan, and the residents' choices and based on the comprehensive assessment of a resident for 1 of 12 residents (Resident #43) reviewed for quality of care. - CNA-E failed to transfer Resident #43 using a gait belt as an assistance device to prevent accidents. CNA-E hooked her arm under Resident #43's arm, pulling upward to transfer resident from the bed to the wheelchair. This failure could place residents at risk of pain, injury, or hospitalization. Record review of Resident #43's face sheet dated 06/11/25 revealed a [AGE] year-old admitted to the facility on [DATE] and originally admitted on [DATE]. The diagnoses included dementia, stroke, swallowing disorder, language disorder, arthritis, muscle weakness and delusional disorders. Record review of Resident #43's annual MDS dated [DATE] revealed a BIMS score of 3 out of 15 indicating severe cognitive impairment. She required substantial/maximal assistance with toileting, sit to stand: helper does more than half the effort; helper lifts or holds trunk or limbs and provides more than half the effort. Resident #43 was frequently incontinent of bowel and bladder. Resident #43 had no functional limitations in range of motion to the upper extremities or lower extremities and used a wheelchair for mobility. Record review of Resident #43's undated care plan revealed: Focus- the resident had impaired cognitive function and impaired thought processes and may miss the intent when spoken to d/t Moderate Dementia with Behaviors. BIMS score of 5. Goal- will maintain current level of decision-making ability by review date. Target date 06/18/25. Interventions included - Cue, reorient and supervise as needed. Don't argue or correct me if I get confused to reality. Identify yourself at each interaction. The resident understands consistent, simple, directive sentences. Provide the resident with necessary cues-stop and return if agitated. Focus - Resident #43 has an ADL self-care performance deficit r/t Dementia and stroke. Interventions included - Provide the following assistance with ADLs in self-performance and staff support, Transfer - limited-total assist of 1; Toileting - limited-total assist of 1. Focus - Resident at risk for falls and injury r/t gait/balance problems. Poor communication/comprehension, poor safety awareness, psychoactive drug use, vision/hearing problems. Goals included - Resident #43 will not sustain serious injury through the review date. Interventions included - anticipate needs, provide prompt assistance with ADLs and other special needs. Record review of Resident #43's Therapist progress note dated 3/24/25 at 2:03 PM and written by the Occupational Therapist read in part: Therapist spoke with RP about resident being a one-person transfer. RP was agreeable. Therapist explained that being a two-person transfer would hinder patients' independence and resident to become more dependent on staff. Therapist findings Minimum assistance from chair to bed, Moderate assistance from bed to chair . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675739	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood at the Woodlands	10450 Gosling Rd The Woodlands, TX 77381

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility staff in-service dated 3/24/25, for Transfers (Resident #43) and conducted by Therapy revealed Resident #43 was a one person assist; all staff must use gait belt for sit to stand transfers; do not pick resident up from the arms; allow resident to use bedrail or wheelchair to grab on for transfer. Record review of Resident #45's face sheet dated 06/20/2025 revealed a [AGE] year-old admitted to the facility on [DATE]. Diagnoses included fracture of the thigh bone, Parkinson's disease, anxiety, and dementia. Record review of Resident #45's quarterly MDS dated [DATE] revealed a BIMS score of 15 out of 15 indicating intact cognition. Record review of the facility investigation summary revealed on 05/31/25 Resident #43's roommate Resident #45 reported that she overheard Resident #43 say ouch during incontinent care. The charge nurse assisted with the remaining care and then removed CNA-E from the room to investigate. Resident #43 made no allegations but stated she no longer wanted CNA-E. Resident #43 was immediately assessed, and no injuries or distress was observed. The RP was contacted by the weekend supervisor and notified of the roommate's concern and asked that the camera footage be reviewed. CNA-E was sent home. The RP reported that CNA-E did not seem to know how to put a diaper on but made no further allegations. The facility-initiated interviews with other residents to ensure there were no other concerns as per protocol. Further review of the facility investigation revealed the RP had a meeting with the Administrator and the DON on 6/2/25 to discuss customer service concerns after reviewing the camera footage and reported that the CNA over the weekend was rough with the resident during incontinent care. The CNA was identified as CNA-E. Continued review of the facility investigation included a statement from CNA-E which read in part: . After she was changed, and her clothes was put on I told her we will transfer to the wheelchair, and I needed her assistance to do so. As I sat her up and tried to assist her with standing she began to yell again, and I stopped and went and got the nurse because she did not want to get up. Resident #43 was reassessed, no delayed or new injuries observed, resident continued to deny pain and exhibited no signs or symptoms of psychological distress. The facility notified the Agency service of the allegation. CNA-E had been marked as do not return to the facility. Continued review of the investigation report revealed Resident #43 remained at her baseline with no adverse outcomes. Observation on 6/18/25 at 2:30 PM of the undated video footage #3 submitted by Resident #43's RP revealed that CNA-E had just completed incontinent care for Resident #43 and sat Resident #43 up on the edge of the bed. Resident #43 said I can't do it. CNA-E stated, yes you can, c'mon - one-two-three. CNA-E hooked her arm under Resident #43's right armpit and attempted to assist her in standing up and pulled upward under the arm and at the waist band of the pants. Resident #43 said oww-ouch! CNA-E said, you have to grab the wheelchair, put your had up here - one two three. CNA-E pulled under her arm and at her sweatshirt. Resident #43 said ouch-ouch-ouch, it's killing my thigh, gosh all mighty I don't need you! Resident #43 sat back on the bed. CNA-E stated, you have to hold on to the chair. CNA-E straightened out Resident #43's sweatshirt then walked out of the room and returned with LVN-B. LVN-B gave verbal instructions to Resident #43 and together with CNA-E, Resident #43 was transferred from the bed to the wheelchair without incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675739	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood at the Woodlands	10450 Gosling Rd The Woodlands, TX 77381

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 06/18/2025 at 1:45 PM, Resident #43 was sitting in a wheelchair in the TV room. She was very pleasant, calm and in no apparent distress. When asked if anyone was rough with her or made her feel bad, she stated not that she knew of and stated she was having a good day. On 06/19/2025 at 2:30 PM, telephone contact was attempted on three different occasions to reach out to CNA-E. The contact number did not allow to leave a voicemail. Telephone interview on 06/19/2025 at 11:56 AM, LVN-B stated she did not see the incident with CNA-E and Resident #43 and that she only assisted after CNA-E asked for help because the resident was not allowing anyone to help her. LVN-B stated she was attempting to deescalate and that she did not see anything physical. LVN-B stated Resident #43 needed a lot of direction with ADLs and with proper cueing she was able to get up on her own. LVN-B stated if Resident #43 was unable to stand she would try to use a sit-to-stand assistive device. In an interview on 6/20/2025 at 2:05 PM, the Corporate Nurse stated she expected nursing staff to check the resident's Kardex regarding transferring needs: whether a mechanical lift was needed, if resident was a 2 person assist or if the resident required use of a gait belt but not hooking arm under the resident's arm. The Corporate Nurse stated she expected the nursing staff to get help if the resident was not getting up as usual. In an interview on 06/20/2025 at 2:10 PM, Resident #45 stated the curtain was pulled and she thinks it was an aide from the agency who was getting Resident #43 dressed when she heard her say ouch several times. Resident #45 stated she must have been transferring her when she started hollering and saying ouch that hurts. Resident #45 stated that was when the aide went to get help and brought the nurse. Interview on 6/20/2025 at 2:25 PM, the Administrator stated when the surveyors exited the first time on 5/23/25, there was ongoing in-services when abuse and all other areas of concern were substantiated. The Administrator stated abuse in-services started again on 5/30/25, the day before the 5/31/25 incident involving Resident #43. The Administrator stated she added quizzes on abuse and random resident interviews included rights and dignity. Peri-care in-services started due to the initial report from Resident #43's RP that CNA-E did not know how to change briefs and included in-services on Dementia, specific in-service on Resident #43's plan of care. The Administrator stated added in services were in place with the Agency before 5/31/25 and that CNA-E completed all the required inservices on 5/13/25, then worked one day only on 5/31/25. Record review of the facility's staff training excel spread sheet revealed CNA-E completed Abuse training and Expectation and Education training on 5/13/25. Further review of the Expectation and Education training acknowledgement read in part: .You must sign the staffing Binder and the Agency Education Binder when you arrive to the facility each shift. You are expected to understand and comply with all binder contents and will be held to that standard .Expectations: .name tag and Gait belt . Continued review revealed CNA-E signed the acknowledgment. Record review of the facility's staff in-service dated 06/01/25, topic: Resident #43's plan of care, included - always explain to resident what you are doing prior to starting care. Continue to explain as care progresses. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675739	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood at the Woodlands	10450 Gosling Rd The Woodlands, TX 77381

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy and procedure for Safe Resident Handling/Transfers revised on 04/2023 read in part: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines Compliance Guidelines: .5. Handling aids may include gait belts, transfer boards, and other devices 14. Resident lifting transferring will be performed according to the resident's individual plan of care. Record review of the facility in-service dated 6/10/25, topic: Mechanical Lifts, safe Transfers, Gait Belts, Transporting Residents revealed: Gait belts should be used with all transfers not involving a mechanical lift; gait belts are a required part of the CNA uniform .our goal is to help residents improve and maintain their independence.