

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 05/29/2024
NAME OF PROVIDER OR SUPPLIER Ridgmar Medical Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227</p> <p>Based on interview and record review the facility failed to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the discharge was necessary for the resident's welfare and the resident's needs could not be met in the facility for 1 (Resident #1) of 2 residents reviewed for discharge requirements.</p> <p>The facility failed to provide and document sufficient preparation to ensure safe and orderly discharge for Resident #1, when they claimed he was being sexually inappropriate with Resident #2.</p> <p>This failure could affect residents by placing them at risk of being discharged and not having access to available advocacy services, discharge/transfer options, and appeal processes.</p> <p>Findings included:</p> <p>1. Review of Resident #1's MDS dated [DATE] revealed the resident was an [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included atrial fibrillation (irregular and very rapid heartbeat), coronary artery disease (the heart does not get enough oxygen-rich blood), diabetes, difficulty walking, and history of malignant neoplasm of prostate. The MDS reflected the resident had a BIMS of 12, cognition moderately impaired, and there was no history of having behaviors that included public sexual acts. The MDS further reflected Resident #1 used a wheelchair for mobility and had impairment to both sides of his upper extremities.</p> <p>Review of Resident #1's care plan initiated on 11/22/23 reflected the following: The resident significantly intrudes on the privacy or activities of others. Goes into other rooms and attempts to touch/kiss female residents. Interventions included 30 day discharge if needed and redirect, monitor resident location as needed.</p> <p>2. Review of Resident #2's MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included vascular dementia ; severe with other behavioral disturbance, and cerebral infarction (heart attack). The MDS further reflected the resident had memory problems and cognitive skills for daily decision making were moderately impaired.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's care plan initiated on 05/29/24 (date surveyor entered visit) reflected the resident had impaired cognitive function/dementia or impaired thought process related to dementia and impaired decision making. The care plan further reflected the resident was at risk for receiving inappropriate behavior from other resident due to BIMS score - indicating decision making. Interventions included to monitor/document/report any inappropriate behaviors towards residents and protect resident from unwanted behaviors.</p> <p>Review of Resident #1's progress noted dated 11/20/23 revealed the following: (incident previously investigated)</p> <p>resident went into room [ROOM NUMBER] and woke up the female resident and refused to get out stating 'I have every right to be in here' resident was seen hugging and kissing the resident and still refused to get out of the room, administrator was called and the resident refused to talk to him, per the admin the police was called and the resident's [family member] as well.</p> <p>Review of the facility's Provider Investigation Report dated 03/13/24 revealed the following:</p> <p>On 03/13/24 [Resident #1] was seen rubbing the arm and shoulder of [Resident #2] by social services director. This action appeared to be inappropriate behavior to the witness between a cognizant resident and one that may not give informed consent. The Provider Investigation Report further reflected that due to the history and continued observed behaviors Resident #1 was identified as an immediate threat to the safety of other residents and was discharged on [DATE] with the assistance of the police.</p> <p>Review of the facility's Notice of Resident/Transfer/Discharge provided to Resident #1 dated 11/27/23 revealed the following:</p> <p>.This letter is to inform you of our intent to transfer/discharge you thirty (30) days from above date due for the following reason(s):</p> <p>The safety of individuals in the facility is endangered by the resident being there.</p> <p>You have the right to appeal this decision to the appropriate state long term care agency at the address provided below. If you need help obtaining an appeal form or assistance in completing the form or submitting the appeal hearing request, contact the facility Social Worker at the facility</p> <p>Review of the letter Fair Hearing - Nursing Facility Discharge for Resident #1 dated 03/04/24 revealed the following:</p> <p>.The undersigned designee of the Executive Commissioner, having received and considered the evidence submitted in this matter, is of the opinion that the preponderance of the evidence establishes that the action on appeal was not in accordance with applicable law and policy. Therefore, that action is REVERSED.</p> <p>Instructions:</p> <p>[Nursing Facility] is to rescind the discharge notice issued on November 27, 2023, and cease any discharge action associated with that notice</p> <p>(continued on next page)</p>

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>.A. Purpose of Fair Hearing</p> <p>The purpose of the hearing was to determine whether the involuntary discharge of the Appellant from a Medicaid-certified nursing facility, based on the safety of individuals in the facility being endangered by the Appellant, was in accordance with applicable law and policy</p> <p>Attempts to contact Resident #1 on 05/28/24 and on 05/29/24 were unsuccessful.</p> <p>Resident #2 no longer resided at the facility at the time of the investigation.</p> <p>Review of Resident #1's progress notes dated 03/13/24 documented by the Social Worker revealed the following:</p> <p>LMSW was walking down the hallway and saw [Resident #1] rubbing the arm and shoulder of a female who is not able to consent. CNA staff moved the female resident away from [Resident #1] and he followed her over to the table she was sitting at. LMSW immediately told both the DON and Administrator of what was just witnessed. Administrator told LMSW to call the son of [Resident #1] to inform him he will be discharging immediately, and he will need to be picked up before 5pm or he will be taken to [hospital]. Son of [Resident #1] said that he would be up here soon.</p> <p>Review of Resident #1's progress notes dated 03/13/24 documented by the Administrator revealed the following:</p> <p>03/13/24 Social Worker reported to administrator that [Resident #1], BIMS 15 of 15 was seen in what appeared to be 'inappropriate behavior' and touching between himself and [Resident #2]. [Resident #2] a female resident who tested 4 of 15 03/13/24. Due to [Resident #2] previous behaviors with this exact resident and others all involving resident who may not give informed consent, the facility had identified [Resident #1] an immediate threat to the safety of other female non- cognizant residents .</p> <p>Interview on 05/29/24 at 11:45 AM, the Social Worker revealed the day of the incident between Resident #1 and Resident #2, 03/13/24, state surveyors were in the building and Resident #1 was sitting by the nurse's station and saw him rub Resident #2's hand and went up to rub her shoulder. At that time the Social Worker went to get the Administrator and the DON and Resident #1, and Resident #2 were separated. Resident #1 was told that was inappropriate and the resident needed to keep his hands to himself and after that, the Administrator took over. The Social Worker said that in the past, Resident #1 had already been told to keep his hands to himself because he was touchy/feely with females. To her knowledge Resident #1 did not touch the females on their breast or vaginal area. Resident #1 got a 30 day discharge notice in November 2023 for going in and out of female resident rooms and would refuse to leave claiming he had the right to visit in there. The Social Worker further stated Resident #1 got an immediate discharge on 03/13/24 when he was seen feeling up Resident #1's arm. The police were called and had to escort Resident #1 out of the facility, during that incident, because Resident #1 became disruptive because he did not want to leave.</p> <p>Record review of an interview submitted via email received and dated 06/04/24, after surveyor exit, by the Social Worker revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/13/24 I was walking down the 100 hallway and saw [Resident #1] take his hand and feel up [Resident #2's] up towards her chest. When I saw this occur, I immediately notified the [DON] and [Administrator] who were in the [DON's] office. After I notified them and looked again the staff had already separated the residents but [Resident #1] was wheeling back over towards [Resident #2]. This was sexually inappropriate behavior. [Resident #2] is alert and oriented and has had two prior sexual inappropriateness towards other residents. [Resident #2] is not able to consent to this behavior due to her cognitive impairments.</p> <p>Interview on 05/29/24 at 3:42 PM, the DON revealed the day Resident #1 was discharged from the facility, 03/13/24, State was in the building, and they were in the middle of an Immediate Jeopardy (IJ). Prior to the recent incident, 03/13/24, there had been two other reportable incidents where Resident #1 had been sexually inappropriate. Resident #1 and his family had been told that if Resident #1 continued to touch another resident, which did not have the ability to consent, the resident would be immediately discharged . During the incident on 03/13/24 she was in her office, and she saw Resident #1's hand going towards Resident #2's breast so she separated both the residents. The incident was reported the Administrator and the family picked the resident up and took him home. The DON said they had tried to discharge Resident #1 in the past, but they had lost the appeal. After the incidents related to the appeal, Resident #1 was being monitored because he continued to touch female residents. Because certain residents could not consent Resident #1 was told he could talk to those residents out in the open but could not go into their rooms. Because of the IJ they had gotten, the Administrator said Resident #1 had to be discharged immediately.</p> <p>Record review of an interview submitted via email received and dated 06/04/24, after surveyor exit, by the DON revealed the following :</p> <p>I was in my office which is directly across the Residents TV sitting area when the Social Worker came to my office stating [Resident #1] was rubbing up the arm of [Resident #2]. When I got out of my chair and around my desk [Resident #2's] hand was rubbing across her upper chest towards her breast. At the same time staff was separating him from her.</p> <p>Resident #1 is alert and oriented with history of sexual inappropriateness that had been involved in 2 previous self reports regarding this. [Resident #2] however had a low BIMS and was unable to give consent for a physical relationship.</p> <p>As you know surveyors were in our facility that very day 03/13/24 citing us for an IJ for NOT keeping resident safe from sexual inappropriateness.</p> <p>The immediate discharge was our only option to keep [Resident #2] and any other female resident safe.</p> <p>During our last survey on 05/30/24 we explained this situation to [Surveyor] very clearly several times. However, she chose to cite us based on her opinion instead of facts.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/29/24 at 3:17 PM, the Administrator revealed there was a resident (Resident #2) who Resident #1 had previous interactions with when she stayed for a short respite stay that were not condoned by the facility when he kissed Resident #2. The second time Resident #2 was at the facility again for another respite stay Resident #1 was seen rubbing Resident #2's arm. There was another incident where Resident #1 entered a female resident's room and the resident refused to leave when he was asked but there was nothing inappropriate of sexual during that incident that he was aware of. Shortly after they had a care plan meeting with Resident #1 where he was told there were resident who could not give consent to touching and the resident said he understood. Resident #1 was given a 30 day discharge notice due to the incidents and the resident appealed the discharge and won. The Administrator said they were in the middle of an IJ with another resident with similar behaviors so that is why Resident #1 was given an immediate discharge.</p> <p>Interview on 05/29/24 at 10:51 AM, LVN A revealed Resident #1 did not have any behaviors during her shift and mainly visited with other residents at the tables in the activity or TV area. The LVN stated she never saw the resident be inappropriate with females during her shift. LVN A further stated they tried to keep the resident around the nurse's station area so they could monitor due to previous incidents she had been told about related to entering female resident rooms.</p> <p>Interview on 05/29/24 at 1:30 PM, CNA B revealed that towards the end of Resident #1's stay at the facility the resident required more assistance with ADLs. The resident could be verbally abusive and yell and scream at the staff. There were times he would hold female resident's hand and rub their arm but the staff just made sure Resident #1 stayed where they could see him.</p> <p>Interview on 05/29/24 at 2:16 PM, CNA C revealed Resident #1 always complained about the staff because he liked things a certain way and would become impatient. The CNA stated she never saw the resident entering other resident's rooms but was only told by other staff but there were times he would hold another female resident's hands. All staff were told to monitor Resident #1 to make sure he did not enter female resident rooms.</p> <p>Interview on 05/29/24 at 4:01 PM, LVN D revealed Resident #1 did not like to be told what to do and would threaten to call the ombudsman or state if things did not go his way. There were times the LVN witnessed Resident #1 hold hands with Resident #2 and placed his hand on her knee but did not witness anything inappropriate. LVN D stated Resident #2 had two respite stays at the facility and during the first stay Resident #2 would allow Resident #1 to hold her hand. The second time Resident #2 was at the facility Resident #1 did not appear to understand that Resident #2's dementia had progressed and she did not recognize him and Resident #1 just assumed staff was trying to keep them away from each other. LVN D further stated he never observed anything sexual between Resident #1 and any female residents.</p> <p>Review of the facility's policy titled Discharging the Resident revised December 2016 reflected the following:</p> <p>Purpose</p> <p>The purpose of this procedure it to provide guidelines for the discharge process.</p> <p>Preparation</p> <p>(continued on next page)</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227</p> <p>Based on interview and record review, the facility failed to notify the resident, resident representative and send a copy to the Office of the State Long-Term Care Ombudsman, of the transfer or discharge and the reasons for the move in writing and in a language and manner they understood for one (Resident #1) of two residents reviewed for discharge.</p> <p>The facility failed to notify the Ombudsman of Resident #1's discharge.</p> <p>This failure could put residents at risk of being discharged and not having access to available advocacy services, discharge/transfer options, and appeal processes.</p> <p>Findings included:</p> <p>Review of Resident #1's MDS dated [DATE] revealed the resident was an [AGE] year-old male admitted to the facility on [DATE] and discharged on [DATE]. His diagnoses included atrial fibrillation, coronary artery disease, diabetes, difficulty walking, and history of malignant neoplasm of prostate. The MDS reflected the resident had a BIMS of 12, cognition moderately impaired.</p> <p>Review of Resident #1's progress notes dated 03/13/24 documented by the Social Worker revealed the following:</p> <p>LMSW was walking down the hallway and saw [Resident #1] rubbing the arm and shoulder of a female who is not able to consent. CNA staff moved the female resident away from [Resident #1] and he followed her over to the table she was sitting at. LMSW immediately told both the DON and Administrator of what was just witnessed. Administrator told LMSW to call the son of [Resident #1] to inform him he will be discharging immediately and he will need to be picked up before 5pm or he will be taken to [hospital]. Son of [Resident #1] said that he would be up here soon.</p> <p>Review of Resident #1's progress noted dated 03/13/24 documented by the Administrator revealed the following:</p> <p>03/13/24 Social Worker reported to administrator that [Resident #1], BIMS 15 of 15 was seen in what appeared to be 'inappropriate behavior' and touching between himself and [Resident #2]. [Resident #2] a female resident who tested 4 of 15 03/13/24. Due to [Resident #2] previous behaviors with this exact resident and others all involving resident who may not give informed consent, the facility had identified [Resident #1] an immediate threat to the safety of other female non-cognosente residents. [Resident #2's son is notified and discharge care-plan meeting convened to establish safe destination. The [son] resides in [Resident #2] home, whose needs may be met there with home health services. If the son refused to take [Resident #2], the facility must discharge to [Hospital] ER immediately. Immediate notice of discharge issued, and ombudsman notified.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/29/24 at 11:45 AM, the Social Worker revealed the day of the incident between Resident #1 and Resident #2, 03/13/24, state surveyors were in the building and Resident #1 was sitting by the nurse's station and saw him rub Resident #2's hand and went up to rub her shoulder. At that time the Social Worker went to get the Administrator and the DON and Resident #1 and Resident #2 were separated. Resident #1 was told that was inappropriate and the resident needed to keep his hands to himself and after that, the Administrator took over. The Social Worker said that in the past, Resident #1 had already been told to keep his hands to himself because he was touchy/feely with females. To her knowledge Resident #1 did not never touched the females on their breast or vaginal area. Resident #1 got a 30 day discharge notice in November 2023 for going in and out of female resident rooms and would refuse to leave claiming he had the right to visit in there. The Social Worker further stated Resident #1 got an immediate discharge on 03/13/24 when he was seen feeling up Resident #1's arm. The police was called and had to escort Resident #1 out of the facility, during that incident, because Resident #1 became disruptive because he did not want to leave. The Social further stated she thought she sent the discharge notice to the ombudsman the evening of the incident, 03/13/24, after Resident #1 was discharged then then the Social Worker stated she could not find the email to the Ombudsman unless she had forgotten to send one.</p> <p>Interview on 05/29/24 at 3:17 PM, the Administrator revealed there was a resident (Resident #2) who Resident #1 had previous interactions with when she stayed for a short respite stay that were not condoned by the facility when he kissed Resident #2. The second time Resident #2 was at the facility again for another respite stay and Resident #1 was seen rubbing Resident #2's arm. There was another incident where Resident #1 entered a female resident's room and the resident refused to leave when he was asked but there was nothing inappropriate or sexual during that incident that he was aware of. Shortly after they had a care plan meeting with Resident #1 where he was told there were resident who could not give consent to touching and the resident said he understood. Resident #1 was given a 30 day discharge notice due to the incidents and the resident appealed the discharge and won. The Administrator said they were in the middle of an IJ with another resident with similar behaviors so that is why Resident #1 was given an immediate discharge. The Administrator said he placed a phone call to the Ombudsman to let her know of Resident #2's immediate discharge but did not know if he sent the written notice of the discharge to her. The Administrator then stated, We were in the middle of an IJ, what I was supposed to do, stop what I was doing to send her the notice.</p> <p>Interview on 05/29/24 at 9:00 AM, the Ombudsman revealed she was on vacation the week Resident #1 was discharged from the facility. Upon her return she had a phone message from the Administrator about Resident #1's discharge. She stated the facility would normally send her a list of 30 day discharge notices but she checked her email and she never received a copy of Resident #1's discharge notice. The Ombudsman further stated she expected to be notified as soon as possible of immediate discharges so the residents can be notified of their rights.</p> <p>Review of the facility's policy titled Discharging the Resident revised December 2016 reflected the following:</p> <p>Purpose</p> <p>The purpose of this procedure it to provide guidelines for the discharge process.</p>		