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	04/08/2025

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44786 Based on interview and record review, the facility failed to provide behavioral health services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one (Resident #1) of four residents reviewed for behavioral health services. The facility failed to follow-up to ensure Resident #1 received a psychiatric consultation after a verbal order was received from the NP on 02/12/25. This failure could place residents at risk for not receiving behavioral health services and a decline in quality of life. Findings included: Record review of Resident #1's face sheet, dated 03/14/25, reflected the resident was a [AGE] year-old female, with an admitted [DATE] and a discharge date of [DATE]. It noted Resident #1 was discharged to the hospital. Resident #1 had a diagnosis of Parkinson's Disease with Dyskinesia (a progressive neurodegenerative disorder that affects movement, balance, and coordination), Cognitive Communication Deficit (communication difficulty), and Dysarthria (difficulty in speaking due to damage or dysfunction in the muscle or nerves that control speech). Record review of Resident #1's quarterly MDS assessment dated [DATE], reflected Resident #1 had a BIMS score of 12, which indicted she had moderate cognitive impairment. There were no hallucinations, signs of delusion, or rejection of care noted on the assessment. The Resident Mood Interview in Section D of the MDS assessment noted Resident #1's Total Severity Score was 11, which could indicate moderate anxiety, depression, or other conditions which required further assessment. Record review of the PASRR Level 1 Screening for Resident #1, dated 01/30/25, reflected Resident #1 did not have a primary diagnosis for dementia, that the resident did not have mental illness, the resident did not have an itellectual disability or developmental disability. The screening was completed by the case manager at the hospital. Record review of Resident #1's care plan, dated 02/01/25, reflected the following: Focus (continued on next page)

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

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has a psychosocial well-being problem, mood problem, and little interest in doing things, actual r/t ineffective coping Goal The resident will have no indication of psychosocial well-being problem, mood problems, more interest in doing things Record review of a progress note dated 02/12/25 at 10:36 AM, documented by LPN Nurse A, reflected the following: Resident seen by NP, complain of depression, new orders for psych consult Record review of a Progress document from the NP, dated 02/13/25, reflected the following: Staff concerns regarding depression. Nursing staff request evaluation of patient due to (Family Member) request Plan: Pending psych consult Record review of a progress note submitted by LPN Nurse A on Resident #1's electronic record, dated 02/12/25 at 10:36 AM, reflected the following: Resident seen by NP, complain of depression, new orders for psych consult Record review of Resident #1's electronic record did not reflect any psychiatric consultation, any scheduled consultation, or any follow-up regarding the psych consult order. Record review of the physician's note dated 02/03/25 on Resident #1's electronic record, reflected the following: Resident is alert and oriented x3. Oriented to person. Oriented to time. Oriented to place. Level of cognitive impairment: Alert. Resident is coherent. Speech is clear. Resident makes self understood. Resident understands others. Mood is pleasant, no unwanted behaviors witnessed. Resident sleeps through the night. Resident's psycho-spiritual needs are met. Record review of the physician's note dated 02/13/25 on Resident #1's electronic record, reflected the following: Resident is alert and oriented x3. Oriented to place. Oriented to person. Oriented to time. Resident is coherent. Record review of the physician's note dated 02/16/25 on Resident #1's electronic record, reflected the following: Resident is alert and oriented x3. Oriented to person. Oriented to place. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an emailed interview on 03/13/25, Resident #1's Family Member stated the following: 2/3 (02/03/25), 9:24 AM Concerns start with (Resident #1's) mental health. In our text string (Resident #1) was talking about no one being at the table, am thinking she meant back at Grandview. Noticing a delirium mental state later in the day and at night. In the family chat she mentioned being at a place (that was brand new, so could not have been) and having keys for it. 2/5 (02/05/25), 4:28 PM Called the social worker and he could not answer any of our questions and referred me to the nurse. He said he met with (Resident #1) a couple times and she seems in good spirits and nothing has been brought to his attention. 2/11 (02/11/25), 1:15 PM They are doing a doctor on site consult as (Resident #1) is depressed and I confirmed that too. I explained my concerns with her mental state and bouts of delirium and confusion. (Family Friend) said (Resident #1) is hallucinating because she thinks there is something in her room next to her bed. (Resident #1) also had some emotional moments tonight and said she was depressed. I wondered if (Resident #1) should be back in the hospital? I sent (DON) a text and picture of her food and (Family Friend's) text about (Resident #1's) delirium following our concerns. 2/12 (02/12/25) (Resident #1) is texting more delirium. Said They are waiting and I'm scared 2/13 (02/13/25) She (LPN Nurse A) said (Resident #1) had the psych consult and are waiting to see what meds may be prescribed. Record review of the hospital document dated 02/21/25 reflected Resident #1 arrived at the hospital on 02/20/25, with a chief complaint of possible infection of a wound. It noted Resident #1's behavior was normal but withdrawn. In an interview on 03/14/25 at 9:50 AM, the Administrator stated Resident #1 arrived to the facility from an assisted living facility and was in bad shape. He stated it was almost like Resident #1 was depressed. The Administrator stated she did not want to get out of bed. He stated he never heard of Resident #1 having hallucinations. In an interview on 3/14/25 at 2:50 PM, Caregiver B stated Resident #1 appeared to be depressed. She stated Resident #1 never wanted to get out of bed and liked to lay on one side facing the window. Caregiver B stated Resident #1 was never observed having hallucinations. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/14/25 at 3:03 PM, the Social Worker stated he did not receive any complaints regarding Resident #1's mental state. He stated he only spoke with Resident #1's family members about physical therapy and preparing the resident to return to the assisted living facility. He stated he was not aware that Resident #1 was depressed. In a follow-up interview on 03/14/25 at 3:16 PM, the Social worker stated he would review the resident's electronic file and suggest psych services, or the NP would suggest or order psych services. He stated he was not aware Resident #1 needed psych services. He stated he did not recall anyone one, family, friends, or staff stating Resident #1 needed psych services or was possibly depressed. The Social Worker stated a resident's need for psych services is important and would have been processed immediately. In a telephone interview on 03/14/25 at 4:39 PM, LPN Nurse A stated she received a verbal order from the NP for psych services for Resident #1 on 02/12/25. LPN Nurse A stated Resident #1 did not like to leave her room, but she never saw her hallucinate. She stated she informed the Social Worker about the psych services order at the staff meeting the following day. LPN Nurse A stated she documented the psych services order in the progress notes, but she stated she failed to put the order in the system. LPN Nurse A stated usually when she received a verbal order, she would document in the progress notes, put the order in, print it, then would verbally tell the Social Worker. LPN Nurse A stated the risk of not putting the order in the system was Resident #1 did not receive the service. In an interview on 03/14/25 at 5:00 PM, the DON stated the facility had a standing order for psych services. She stated the facility staff had clinical meetings daily, and she stated she did not recall that verbal order for Resident #1 to get psych services. The DON stated she believed LPN Nurse A failed to put the order in the system. The DON stated the family voiced concern about Resident #1's hallucinations and delusion. She stated they had the pain managment team visit Resident #1 to ensure she was not overmedicated with the pain medications. The DON stated, after that it seemed there were not as many hallucinations. In a telephone interview on 03/14/25 at 5:08 PM, the NP stated she did recall that she gave a verbal order to a nurse for Resident #1 to receive psych services. She stated usually she did not work on the skilled hall but LPN Nurse A pulled her into Resident #1's room to assess the resident. She stated she gave the nurse a verbal order to have Resident #1 assessed for depression or anxiety on 02/13/25. In an follow-up interview on 03/14/25 at 5:12 PM, the DON stated she was not present at the facility the day the verbal order was given and she was not sure if the order got exchanged. She stated if a nurse received a verbal order, the nurse would document it, write the order, and discuss any referrals in the stand up meeting. The DON stated that was how verbal orders were usually discussed. The DON stated once the order was submitted, the Social Worker would go in and process the request for psych services. The DON stated during the morning meetings they would usually pull the progress notes and review, so she still was not sure how that verbal order was missed. The DON stated the bottom line was the verbal order was missed. The DON stated the risk was the referral was not processed, so the resident did not receive the services. (continued on next page)

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