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	08/14/2025

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 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. (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

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to incorporate the recommendations from the PASRR Level II determination and the PASRR evaluation report into a resident's assessment, care planning, and transitions of care for 2 of 4 residents reviewed (Residents #2 and #3) for PASRR assessments.The facility failed to submit a Nursing Facility Specialized Services (NFSS) form by the specific deadline for Resident #2 and Resident #3.The failure placed residents at risk of not receiving specialized services and equipment which could decrease their quality of life.Findings included:Record review of Resident #2's annual MDS assessment, dated 06/26/25, reflected the resident was a [AGE] year-old male, who admitted to the facility on [DATE]. The resident's diagnoses included 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). Resident #2's BIMS score not completed due to the resident was rarely/never understood. Resident #2 was noted to have impairment to both sides of his upper and lower extremities, and he did not use any of the mobility devices listed. Resident #2 was dependent (meaning helper did all of the effort and the resident did none of the effort to complete the activity) for chair/bed-to-chair transfers.Record review of Resident #2's care plan, revised 04/16/25, reflected Focus: PASRR positive R/T pt identified as having PASRR positive status related to an intellectual disability. (The following meetings completed, and services reviewed) PCSP 7/25/24. Habilitation coordination, ILS, PT and CMWC. PCSP 10/24/24. Habilitation coordination, ILS, PT, pcsp: 1/22/25 hc/pt/mcwc/ ILST. pscp: 4/16/2025 hc/pt/cmwc, ilst/ot. Goal: will maintain highest level of practice wellbeing for the next 90days. Interventions: provide service coordination with representative from LIDDA. report any need to evaluate for services and/or durable medical equip to maintain currently level of function. Record review of Resident #2's HSP dated 07/15/25 reflected the following: .Section 6, NF Specialized Services to be Monitored by the SPT .Name of Service: Customized Manual Wheelchair . Outcome/Goal: Pending assessment. Section 7, Preference Regarding Transitioning. Barrier identified by the SPT: [Resident #2] is waiting for a CMWC . signed by the Habilitation Coordinator.Record review of Resident #2's PCSP Form, dated 07/15/25, reflected under the section Nursing Facility Specialized Services, a number 3 was marked next to Customized Manual Wheelchair (CMWC) which indicated it was ongoing. Under the comments section next to LA-IDD Specialized Services Comments reflected: CLO Barriers - [Resident #2] needs a safe wheelchair to be in the community. Record review of emails provided by the Director of Rehab, dated 08/23/24, 11/13/24, and 05/30/25 reflected the Director of Rehab had emailed the previous MDS Coordinator the documents needed to submit for Resident #2's customized wheelchair. Observation and an attempted interview on 08/13/25 at 10:43 AM revealed Resident #2 was in his geri-chair (medical recliner designed to provide support and comfort for individuals who require extended sitting periods or have difficulty with mobility) in the common area. Resident #2 was not able to answer questions due to his condition. The resident did not appear to be in distress or discomfort.Record review of Resident #3's quarterly MDS assessment, dated 06/25/25, reflected the resident was a [AGE] year-old male, who admitted to the facility on [DATE]. The resident's diagnoses included progressive neurological conditions (any disorder of the nervous system), cerebral palsy (a group of disorders that affect movement and muscle tone or posture), cerebrovascular accident (sudden loss of blood flow to the brain, causing brain tissue damage) 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). Resident #3's BIMS score of 09 indicated moderate cognitive impairment. Resident #3 had no impairment to his upper and lower extremities and did not use any of the mobility devices listed. Resident #3 was independent (meaning resident completes the activity by themself with no assistance from a helper). Record review of Resident #3's care plan, revised 04/16/25, reflected Focus: PASRR positive R/T pt identified as having PASRR positive status related to an intellectual disability, Cerebral Palsy. (The following meetings completed, and services reviewed) PCSP update 8/15/24. Services pending MCD eligibility. meeting 120/24/24. PCSP: 1/22/25 PT/OT/ST/ILST/HC. 4/16/2025 New pscp pt/ot/st/ilst/hc. Goal: will maintain highest level of practice wellbeing for the next 90 days. Interventions: /invite LIDDA representative and RP to attend careplan meeting. Report any need to evaluate for services and/or durable medical equip to maintain currently level of function. Record review of Resident #3's HSP dated 07/15/25 reflected the following: NF

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as is possible and each resident received adequate supervision and assistive devices to prevent accidents for 1 of 8 residents (Resident #1) reviewed for supervision. The facility failed to ensure Resident #1, who had a history of wandering for which he wore a WanderGuard device, was provided with adequate supervision to prevent him from exiting the building on 07/23/25. The resident was observed outside the facility by a staff member, and he was found on the sidewalk near a street sign outside the facility. The noncompliance was identified as past non-compliance. The Immediate Jeopardy (IJ) began on 07/23/25 and ended on 07/24/25. The facility had corrected the noncompliance before the survey began.This failure placed residents at risk of harm and/or serious injury. Findings included:Record review of Resident #1's annual MDS assessment, dated 06/16/25, reflected the resident was a [AGE] year-old male, who was admitted to the facility on [DATE]. The resident's diagnoses included senile degeneration of brain (progressive deterioration of brain tissue and function), unspecified dementia (a condition where the specific type of dementia cannot be identified despite the presence of cognitive decline and memory loss), Type 2 diabetes mellitus (a chronic disease characterized by high level of sugar in the blood), muscle weakness (a condition where your muscles cannot work with the expected amount of force), depression (a mood disorder that causes persistent feelings of sadness and loss of interest), and anxiety disorder (a mood disorder characterized by excessive, persistent, and uncontrollable fear and worry about everyday situations). The MDS reflected Resident #1 had severe cognitive impairment with a BIMS score of 1. The MDS further reflected Resident #1 did not exhibit wandering behaviors. Record review of Resident #1's care plan, dated 06/24/25, reflected Focus: [Resident #1] is an elopement risk/wanderer r/t Impaired safety awareness. Risk for Wandering/Elopement Identified Wanderguard (bracelet detected near a sensor, the system triggers an alert) to right leg. Goal: The resident will not leave facility unattended. Interventions: Identify if there are triggers for wandering / eloping. Identify wandering / elopement de-escalation behaviors. One on one with resident. Wanderguard to right leg-check placement Q shift. Focus: [Resident #1] is an elopement risk/wanderer r/t Impaired safety awareness 7/23/25. Goal: The resident's safety will be maintained through the review date. Interventions: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. WANDER Guard to right ankle and check placement Q shift. Record review of Resident #1's Elopement Risk Evaluation, dated 06/20/25, reflected Resident #1 was at risk for elopement. The evaluation indicated Resident #1 had a history of attempting to leave the facility without informing staff, resident verbally expressed the desire to go home, packed belongings to go home, stayed near an exit door, and resident had wandering behavior. Record review of Resident #1's progress notes dated 07/23/25 at 14:01 [2:01 PM] by LVN C reflected: Writer was in room with a resident when loud voices were heard in the hallway. Writer waked out and saw [CNA D] in the hallway. Writer asked [CNA D] what was wrong? [CNA D] stated [Resident #1] is outside [CNA D] and I went out the back door on 200 hall and observed resident sitting in his wheelchair on the sidewalk smiling and giggling. Resident chair was facing south. Resident was brought back in the building and a head-to-toe assessment was performed which revealed no injuries. Resident was not hot or sweaty, respirations were even and unlabored, temperature was normal and vs stable. DON notified of elopement as well as Dr [Name], NP [Name] and Resident RP [Name]. Record review of Resident #1's Incident Report, dated 07/23/25 at 07:10 AM, reflected Incident location: Outside Incident Description: Nursing Description: Writer was in room with a resident when loud voices were heard in the hallway. Writer waked out and saw [CNA D] in the hallway. Writer asked [CNA D] what was wrong? [CNA D] stated [Resident #1] is outside [CNA D] and I went out the back door on 200 hall and observed resident sitting in his wheelchair on the sidewalk smiling and giggling. Resident chair was facing south. Resident was brought back in the building and a head-to-toe assessment was performed which revealed no injuries. Resident was not hot or sweaty, respirations were even and unlabored, temperature was normal and vs stable. DON notified of elopement as well as Dr [Name], NP [Name] and Resident RP [Name]. Resident Description: I'm going to my wedding. Immediate Action Taken: Description: Resident brought inside facility, full head to toe assessment completed, resident started on 1 on 1 supervision, DON [Name] notified of elopement as well as Dr [Name], NP [Name] and Resident RP [Name]. Injury Type: No injuries observed at time of incident. Level of Pain: 0 Level of Consciousness: AlertMobility: Wheelchair