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	04/15/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials, including to the State Survey Agency where state law provides for jurisdiction in long-term care facilities, in accordance with State law through established procedures for 1 of 4 residents (Resident #1) reviewed for reporting. The facility failed to report injuries of unknown source to HHSC when Resident #1 went to the hospital on [DATE] and was found to have multiple fractures, which included her right 4th, 5th and 6th ribs, her right humeral head (the rounded end of the upper arm bone that forms the ball of the shoulder joint), her right glenoid/scapula, and both of her coracoids (a small hook-like structure on the lateral edge of the scapula). This failure could place residents at risk of not having injuries of unknown origins reported.Findings included: Record review of Resident #1's Discharge MDS Assessment, dated 04/03/26, reflected a [AGE] year-old female, who was admitted to the facility on [DATE] and discharged on 04/03/26 to the hospital. There was not a BIMS calculated for her. Her functional abilities for chair/bed-to-chair transfer and sit-to-stand transfers required the helper to do all of the effort to complete the activity or required two or more helpers to complete the activity as the resident was dependent on staff. She had active diagnoses of age-related osteoporosis (a condition characterized by weakened bones due to the natural aging process, leading to an increased risk of fractures and breaks) and muscle wasting and atrophy (the loss or thinning of muscle tissue, leading to decreased muscle mass and strength). Her MDS indicated she did not have any falls since admission/entry or reentry or the prior assessment. Record review of Resident #1's electronic health record which included her progress notes, orders, care plan, and assessments reflected no mention of a fall or any incident during her stay from 01/22/26 to 04/03/26. Record review of Resident #1's hospital records, dated 04/03/26 to 04/10/26, reflected the following: Hospital Course/Summary: .Patient and [Resident #1's POA] report a history of multiple falls approximately 10 months ago.She has been bedbound since early January, requiring Hoyer lift and maximal assistance for mobility. Patient denies any falls in the past 4 months.In the ED, imaging revealed multiple right-sided rib fractures.#1 multiple traumatic fractures: -Right ribs (4-6), right humeral head, right glenoid/scapula, bilateral coracoid. Further review reflected: Clinical Notes.Intervention: .Pt was not very clear on how she received all the fractures other than to say, ?I the [sic] sling they had on the Hoyer lift, split and fell out of it. I hit my whole body on the bed and floor.' When SW called the facility to obtain an explanation on what they knew about the pts [sic] having multiple fracture [sic], [the Marketing Director] [the Marketing Director's phone number], in admission states, ?I checked with my director of nursing and no one knows anything about the pt falling or having any issues.' Record review of the facility's incidents/accidents log from January 2026 to April 2026 did not reflect any incidents that (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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	involved a Hoyer lift transfer and Resident #1. An attempted phone interview on 04/14/26 at 9:59 AM was made to Resident #1, but she did not answer and did not call back prior to exit. A voicemail message was left for her to call the state surveyor back. In a phone interview on 04/14/26 at 9:28 AM, a Concerned Party revealed Resident #1 was sent to the hospital where it was found she had multiple fractures. The Concerned Party said she talked to the facility's Marketing Director to see if anything happened at the facility that would have caused the injuries she sustained. The Concerned Party said she was told by the Marketing Director the facility was not aware of anything that could have caused Resident #1's injuries. In a phone interview on 04/14/26 at 8:43 AM, Resident #1's POA said Resident #1 went to the hospital on [DATE], and the hospital found that the resident had fractured shoulder blades and ribs. Resident #1's POA said Resident #1 was bedbound, and she was never made aware of any incidents that would have caused these injuries to the resident. Resident #1's POA said Resident #1 told her and the hospital that she fell during a Hoyer lift transfer at the facility, but she did not have any other details. In a phone interview on 04/14/26 at 12:08 PM, LVN A said she cared for Resident #1 mostly at night. LVN A said she never heard of Resident #1 having a fall from a Hoyer lift, never saw her have any unexplained bruising, and never noticed her being in any pain. LVN A said Resident #1 never presented as if she had fractures of any kind. LVN A said she never heard that Resident #1 had any falls or incidents that would cause any fractures or injuries while at the facility. In an interview on 04/14/26 at 12:13 PM, RN B said she cared for Resident #1 often. RN B said Resident #1 never presented with any pain, did not have any falls while at the facility, and never presented as if she had any fractures. RN B said she had never heard of Resident #1 falling from a Hoyer lift transfer. RN B said Resident #1 was on a blood thinner medication but did not have any unexplained bruising to her body. In a phone interview on 04/14/26 at 12:30 PM, RN D said she cared for Resident #1 for a few days but never noticed any bruising on her body. RN D said Resident #1 never complained of pain and had no falls that she was aware of. RN D said she never heard that Resident #1 fell from a Hoyer lift transfer.In an interview on 04/14/26 at 12:32 PM, CNA I said she cared for Resident #1. CNA I said she never noticed any bruising to Resident #1's body, she never complained of pain, and she never had a fall or a fall from a Hoyer lift that she knew of. CNA I said Resident #1 never presented like she had any fractures. In a phone interview on 04/14/26 at 12:36 PM, CNA F said she cared for Resident #1. CNA F said she never noticed any bruising on Resident #1's body, Resident #1 never complained of pain, and as far as she knew Resident #1 never had a fall or fell during a Hoyer lift transfer. CNA F said she never noticed Resident #1 acting as if she had fractures to her body. In an interview on 04/14/26 at 12:46 PM, the WCN said she saw Resident #1 to treat her wounds. The WCN said she never saw Resident #1 have any unexplained bruising, she never complained of pain, she never had a fall that she was aware of, and never had fall from a Hoyer lift. The WCN said Resident #1 never presented as if she had fractures to her body. In an interview on 04/14/26 at 12:50 PM, the ADON said Resident #1 never complained of pain, did not present as if she had any fractures, never had any falls or falls from a Hoyer lift transfer that she was aware of. In an interview on 04/14/26 at 12:57 PM, the Marketing Director said she had only been working at the facility for 7 days. The Marketing Director said she did speak with the case worker from the hospital who informed her Resident #1 had a broken clavicle, scapula, finger, collar bone, and bruising when she was admitted to the hospital on [DATE]. The Marketing Director said she told the case worker from the hospital she would look into what happened because she was not aware of any incidents at the facility that would cause those injuries to Resident #1. The Marketing Director said she talked to the DON about what she was told and explained to the hospital they were not aware of how Resident #1 could have become injured since nothing happened at the facility. In an interview on 04/14/26 at 1:21 PM, Central Supply said she was informed Hoyer lift slings needed to be replaced every 6 months. Central Supply said she had replaced all Hoyer lift slings in the facility as of February 2026 because they were 6 months old. Central Supply said she had not been informed of any Hoyer lift sling that was broken, frayed, or in disrepair that needed to be replaced since February 2026. Observation (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 04/14/26 at 1:23 PM, with Central Supply and the DON in the laundry area of the facility, the Hoyer lift slings that were recently laundered were in good condition and did not show any signs of wear or tear. In a phone interview on 04/15/26 at 8:57 AM, LVN J said Resident #1 never complained of any pain, never had any falls, never presented as if she had any fractures, and never had a fall from a Hoyer lift transfer that she was aware of. In a phone interview on 04/15/26 at 9:02 AM, RN E said she cared for Resident #1. RN E said Resident #1 never complained of pain, never presented as if she had fractures, and never had any falls while at the facility. RN E said she was never made aware Resident #1 had a fall from a Hoyer lift transfer. In a phone interview on 04/15/26 at 9:08 AM, Resident #1's Dialysis Clinic's Supervisor said Resident #1 went to the dialysis clinic 3 times per week. Resident #1's Dialysis Clinic Supervisor said Resident #1 never had any falls at the clinic. Resident #1's Dialysis Clinic's Supervisor said the clinic used the Hoyer lift sling that was from the facility. Resident #1's Dialysis Clinic's Supervisor said she never noticed the sling in disrepair or ripped or appeared as if it should not be used. Resident #1's Dialysis Clinic's Supervisor said Resident #1 never presented as if she had fractures, never complained of pain, and never had any unexplained bruises to her body. In a phone interview on 04/15/26 at 9:27 AM, LVN C said she cared for Resident #1 on the weekends. LVN C said she never noticed any bruising to Resident #1's body, Resident #1 never complained of pain, and never presented as if she had fractures. LVN C said she was never made aware Resident #1 had a fall or a fall from a Hoyer lift transfer while at the facility. In a phone interview on 04/15/26 at 9:29 AM, CNA G said he cared for Resident #1. CNA G said he never noticed any bruising to Resident #1, she never complained of pain, and she never presented like she had fractures. CNA G said he was not aware of any falls that Resident #1 had or that she fell during a Hoyer lift transfer. In a phone interview on 04/10/26 at 10:10 AM, the NP said as far as she was aware, Resident #1 only had one complaint of generalized left shoulder pain so a lidocaine patch was ordered and administered for her. The NP said a chest x-ray was also completed on 02/17/26 which did not show any fractures. The NP said no falls were ever reported for Resident #1 or any incidents that would have caused the fractures identified at the hospital. In an interview on 04/15/26 at 10:21 AM, the PTA said she saw Resident #1 three times per week for therapy services. The PTA said she never saw Resident #1 complaining of pain, never knew her to have had a fall, and never heard she had a fall during a Hoyer lift transfer. The PTA said Resident #1 had arthritis in her shoulders and would have generalized pain in that area, but it did not seem to affect the resident. In an interview on 04/15/26 at 10:38 AM, the Van Driver said he took Resident #1 to her dialysis clinic 3 times per week and never saw her in any pain. The Van Driver said he never heard about Resident #1 having a fall, never saw any bruising on the resident's body, and the Hoyer lift sling she sat on appeared in good condition each time he saw it. In a phone interview on 04/15/26 at 10:45 AM, CNA H said he cared for Resident #1. CNA H said he never saw any bruises on Resident #1, she never complained of pain, and never presented like she had any fractures. CNA H said as far as he knew, Resident #1 never had a fall and never fell from a Hoyer lift transfer. In a phone interview on 04/15/26 at 11:54 AM, the Physician said when he saw Resident #1 she never complained of any pain and had no reported falls or incidents that would have caused the identified fractures by the hospital. The Physician said he did not believe the injuries occurred at the facility and thought something could have happened during her transport from the facility to the hospital to cause the injuries. In an interview on 04/15/26 at 1:55 PM, the Administrator said he would be the one responsible for reporting this situation to HHSC. The Administrator said he did not report Resident #1's fractures that were found at the hospital when she went on 04/03/26. The Administrator said the hospital initially reached out to the Marketing Director, but he was not sure what day that was. The Administrator said he was not aware of any incident that could have occurred at the facility to cause Resident #1 to have these injuries that were reported (the fractures). The Administrator said since the facility was not aware of how the injuries occurred, they would be considered injuries of unknown origin. The Administrator said after the facility was informed of the injuries they did start talking to staff who cared for Resident #1, completed in-services with (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff, and did not find that anything occurred during Resident #1's stay that would cause these injuries. The Administrator said he was confused on whether or not he should report the situation with Resident #1 because he was not sure when the injuries happened or how they could have happened. The Administrator said if injuries of unknown origin were not reported to HHSC it could hurt the individual involved. The Administrator said this should have been reported to HHSC within 2 hours because it was the regulation and to keep residents safe. In an interview on 04/15/26 at 2:32 PM, the DON said Resident #1 went to the hospital on Friday, 04/03/26. The DON said she called Resident #1's POA on either Saturday or Sunday (she was not sure which day it was) after she went to the hospital to check on Resident #1. The DON said Resident #1's POA mentioned to her that she had rib fractures but they were not sure how it happened. The DON said she began to interview staff who cared for Resident #1 and in-serviced them as well. The DON said no staff were aware of any incident that could have caused Resident #1's injuries. The DON said she believed the Marketing Director spoke with the case manager from the hospital the following Monday or Tuesday of the next week where it was confirmed the resident had multiple fractures. The DON said the Administrator was the one responsible for reporting this to HHSC and was aware of what the family member told her over the weekend. Record review of the facility's Abuse Investigation and Reporting policy, revised November 2024, reflected: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management.Reporting: 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury.