

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/23/2026
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)		
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a thorough and accurate discharge summary for one of two residents (Resident #1) reviewed for discharge process. -The facility failed to initiate a formal discharge with appropriate documentation when Resident #1 went on therapeutic leave without medications or personal belongings from 06/14/26-06/24/26, which extended beyond Medicaid's bed-hold limit of 3 days. Resident #1 was readmitted to the facility on [DATE] after a hospital stay. This failure could place residents at risk of not receiving ongoing person-centered care, which could lead to worsening conditions or serious harm. Findings included: Record review of Resident #1's Discharge MDS Assessment, dated 06/14/26, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE] and discharged on 06/14/26. The MDS Assessment under Section C-Cognitive Patterns reflected Resident #1's BIMS score was not documented. The MDS Assessment under Section E-Behavior reflected Resident #1 did not hallucinate or have delusions. The MDS Assessment under Section GG-Functional Abilities reflected Resident #1 required setup assistance with most ADLs. Resident #1 used a motorized wheelchair and was independent with mobility. The MDS Assessment under Section I-Active Diagnoses reflected Resident #1's active diagnoses included: chronic atrial fibrillation (heart disorder that causes a rapid and irregular heartbeat), chronic respiratory failure, morbid obesity (body mass index of 40 or higher), diabetes mellitus (the body's inability to regulate blood sugar levels), unspecified dementia (brain disorder that causes loss of memory and thinking), schizophrenia (mental health condition characterized by delusions), and bipolar disorder (mental health condition that causes extreme shifts in mood). Record review of Resident #1's NT/ST MDS Assessment, dated 06/24/26, reflected the resident readmitted to the facility from a short-term general hospital on [DATE] Record review of Resident #1's EHR, under assessments reflected the resident had a BIMS score of 15 which indicated her cognition was intact. Record review of Resident #1's care plan, revised 05/28/26, reflected the resident was able to sign herself out on therapeutic pass. Interventions included: educating the resident on safety precautions while out on pass. The care plan also reflected that Resident #1 frequently left the facility in her electric wheelchair with a history of buying things for other residents with her money when she went out. The resident notified staff when she was leaving. Interventions included: administering medications as ordered and monitoring and documenting effectiveness, anticipating and meeting the resident's needs, providing opportunity for positive interactions, encouraging the resident to allow the facility to purchase needed or wanted items for other residents, and explaining and reinforcing to the resident why behavior was inappropriate. Record review of Resident #1's progress notes, dated 06/14/26 at 8:43 p.m. by RN B, reflected the following: [Resident #1] left the facility with family without signing out. [Resident #1] sitting in W/C awake and alert, no (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 676101 If continuation sheet Page 1 of 3

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	distress or discomfort noted no complain [sic] of pain, [Resident #1] alert and oriented to time and place and self, skin clear no excoriation noted BLE edema nnoted [sic]. Record review of Resident #1's progress notes, dated 06/14/26 at 8:45 p.m. by RN B, reflected the following: [Resident #1] is not back on facility yet, [RN B] called [Resident #1] several time [sic] but no answer, unable to get family on the phone, no phone number listed. Record review of Resident #1's progress notes, dated 06/14/26 at 8:48 p.m. by RN B, reflected the following: [Resident #1] still OOP, [Resident #1] did not returned [sic] call, [RN B] also called [Resident #1] and friends listed on face sheet, no answer, [RN B] also called [local hospitals], [Resident #1] did not sign self into those facility [sic]. DON notify about [Resident #1] status. Record review of Resident #1's progress notes, dated 06/15/26 at 8:15 a.m. by MA C, reflected the following: [Resident #1] oop. Record review of Resident #1's progress notes, dated 06/17/26 at 7:25 a.m. by MA C, reflected the following: [Resident #1] oop. Record review of Resident #1's progress notes, dated 06/24/26 at 9:33 p.m. by LVN D, reflected the following: [Resident #1] arrived via [transportation company] at [3:30 p.m.] in her electric wheelchair from [local hospital] with diagnosis of CHF exacerbation. Upon arrival, vital signs were within normal limits. [Resident #1] was AAO X4 (fully awake and aware or person, place, time, and situation). Skin assessment completed with no skin issues noted. Record review of Resident #1's EHR reflected there was no AMA document or discharge summary completed with details of the resident's recapitulation of stay, current health status, or post-discharge plan. In an interview on 07/23/26 at 2:00 p.m., Resident #1 stated she left the facility last month because she was upset about the facility not helping her get a housing voucher for her own place. Resident #1 stated she chose to leave because she no longer wanted to be at the nursing facility. Resident #1 stated that she left the facility with a family member and did not tell the facility her plans because she was unsure about what she was going to do; however, she ended up getting on a train and going to [NAME], TX. Resident #1 stated she did not take any of her medications or belongings and was homeless in the community for approximately one week before she started swelling with fluid and had to be admitted to the hospital. Resident #1 stated she was able to return to the nursing facility after being discharged from the hospital. In an interview on 07/23/26 at 2:24 p.m. with the Administrator and DON, the DON stated Resident #1 left the facility with family in her electric wheelchair. The DON stated Resident #1's family was recently released from jail and was trying to convince the resident to be on the street with him. The Administrator stated Resident #1 was her own RP and was competent enough to make the decision to leave the facility, and they could not force her to stay. The DON stated when a resident left the facility on therapeutic leave the protocol was for the resident to sign out with medication and provide information for destination and length of time away. The DON stated Resident #1 left the facility without her medication and was at risk due to co-morbidities. The DON stated she notified the MD and he suggested discharging the resident AMA. There was no documented evidence of this notification provided. The DON stated she contacted the local police department to alert them to be in the lookout and called Resident #1's friends and the local hospitals checking for her with no updates initially. The DON stated the facility was later informed that Resident #1 was somewhere in another city and after about a week they found that the resident was in the hospital. The DON stated she had a good rapport with Resident #1 and she wanted the resident to know that she could always return to the nursing facility, and she never thought to start the discharge process. The Administrator stated the facility's discharge policy did not specify at what point an AMA discharge should be initiated. In an interview on 07/23/26 at 3:42 p.m., MA A stated she worked at the facility for about 3 months. MA A stated she worked with Resident #1 and described the resident as independent with most care needs and often out on pass. MA A stated she did not work on the day (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 left the facility, but she was informed during a standup meeting that the resident was missing. MA A stated Resident #1 was away from the facility for about a week, and she had never been away that long. MA A stated she administered Resident #1 her medications and they remained in the mediation cart while the resident was away from the facility. In an interview on 07/23/26 at 4:10 p.m., the MD stated Resident #1 left the facility approximately 5-6 times, but she always returned. The MD stated Resident #1 was competent and had the right to leave the facility if she wanted to. However, he stated from a clinical standpoint, it was dangerous for Resident #1 to be in the community without her medication due to her co-morbidities. The MD stated an AMA discharge should have been completed to provide documentation in the clinical records of the risks involved with the resident leaving and limit the facility's liability. Record review of the facility's policy titled Discharging a Resident Without a Physician's Approval, revised 01/21/24, reflected in part the following: Policy Statement: A physician's order should be obtained for all discharges, unless a resident or representative is discharging himself or herself against medical advice. Policy Interpretation and Implementation: Should a resident, or his or her representative (sponsor), request an immediate discharge, the resident's Attending Physician, Administrator and Director of Nurses will be notified. The order for an approved discharge must be signed and dated by a physician and recorded in the resident's medical record in a timely manner after the discharge. If the resident or representative (sponsor) insists upon being discharged without the approval of the Attending Physician, the resident and/or representative (sponsor) must sign a Discharge AMA Release of Responsibility form. Should either party refuse to sign the release, such refusal must be documented in the resident's medical record.		