

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676197	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Ridgeview Rehabilitation and Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 206 Walls Dr Cleburne, TX 76033	
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents received services in the facility with reasonable accommodations of resident's needs and preferences except when to do so would endanger the health and safety of the resident or other residents for 1 of 5 residents (Resident #49) reviewed for resident rights. The facility failed to ensure Resident's #49's call light was within reach on 12/09/25. This failure could place residents at risk of needs not being met. Findings included: Record Review of Resident #49's face sheet dated 12/11/25 reflected the resident was a [AGE] year-old female admitted on [DATE]. Her diagnoses included Alzheimer's disease (a neurodegenerative disease that usually starts slowly and progressively worsens), anxiety (intense, excessive, and persistent worry and fear about everyday situations), insomnia (a common sleep disorder marked by persistent difficulty falling asleep, staying asleep, or getting quality rest, leading to daytime fatigue, irritability, poor concentration, and mood issues, and it can be short-term (acute, from stress) or long-term (chronic, lasting months), and peripheral vascular disease, also known as peripheral artery disease (a condition that occurs when blood vessels narrow or become blocked, reducing blood flow to the body. Peripheral vascular disease can affect any blood vessel outside of the heart, but it most commonly affects the legs and feet). Record Review of Resident #49's Quarterly MDS assessment dated [DATE] reflected Resident #49 was dependent on staff for showering, toileting, and personal hygiene and required partial/moderate assistance for eating. The MDS reflected Resident #49 had a BIMS score of 01 which indicated Resident #49 was severely cognitively impaired. Record review of Resident #49's care plan dated 04/23/24 and revised on 09/18/24 reflected: Resident was at risk for falls due to limited mobility, poor cognition & poor safety awareness. Goal: Resident #49 would be free of falls through the review date. [Resident #49] would not sustain serious injury through the review date. Interventions included: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. In an observation and interview on 12/09/25 at 2:27 PM Resident #49 was in bed asleep, slightly awakened to name call, and mumbled yes when asked if she was ok. Resident #49 was not showing any signs of pain or distress and appeared to be clean and groomed. The room was clean, and no foul odors were noticed. The resident's call light was not within her reach and was lying with cord going under the nightstand and cord continued over to the side of nightstand away from resident. Resident did not wake up enough to follow directions or attempt to demonstrate if she could have reached the call light. In an interview on 12/09/25 at 2:36 PM with CNA F, he stated in the location where Resident #49's call light was placed, she would not have been able to reach it. He stated he believed the call light had fallen off the bed. He stated he had been trained on call light's being placed within resident's reach at all times. He stated if a resident's call light was not within their reach, resident may have tried to reach for the call light and fell, or the resident could have had an emergency and not have been able to call for help. In an interview on 12/09/25 at 2:44 PM with RN B, she stated all residents' call lights should have been within reach at all times. She stated she had been trained on residents' call light being within their reach at all times. She stated if a resident's call light was not in their reach it could have caused a resident to fall. In an (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 12/11/25 at 10:18 AM, the DON stated it was her expectation that all residents' call lights be within the resident's reach at all times. She stated all staff had been trained on residents' call lights being within reach at all times. She stated if a resident's call light was not within their reach, their needs may not be met in a timely manner. In an interview on 12/11/25 at 10:27 AM, the CNO stated it was her expectation that all residents call lights be within the resident's s reach at all times. She stated all staff had been trained on residents' call lights being within reach at all times. She stated if a resident's call light was not within their reach, there could be an increased risk of falls. In an interview on 12/11/25 at 10:44 AM, the ADM stated it was his expectation that all residents' call lights be within the residents reach at all times. He stated all staff had been trained on residents' call lights being within reach at all times. He stated if a resident's call light was not within their reach, they wouldn't be able to alert or request needed items. Record review of facility policy titled Answering the Call Light and dated 2001 (revised September 2022) reflected Purpose: The purpose of this procedure is to ensure timely responses to the resident's requests and needs. General Guidelines: 5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility failed to ensure resident assessments accurately reflected the resident's status for 1 of 8 residents (Resident #2) reviewed for accuracy of assessments. The facility failed to ensure Resident #2's MDS assessment dated [DATE] was accurately coded for the use and indication of high-risk medications, specifically an antiplatelet medication. This failure could place residents at risk of not receiving the appropriate care, treatment, and services due to inaccurate assessments. Record review of Resident #2's admission record printed on 12/11/2025, reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Hypotension (low blood pressure), dehydration (lost fluids not being replaced), weakness, memory deficit following Cerebral Infarction (problems with memory and thinking after a stroke), and other Cerebral Infarction due to Occlusion or Stenosis of Small Artery (type of stroke caused by blockage of the small arteries in the brain). Record review of Resident #2's physician's orders reflected an order dated 11/25/2025 to monitor anticoagulant (blood thinner) medication, but no anticoagulant medication was ordered. However, review of the physician's orders reflected an order for Clopidogrel (Plavix), an antiplatelet medication (medications that prevent blood clots) instead. Record review of Resident #2's MDS assessment dated [DATE] reflected a BIMS of 11 indicating moderate cognitive impairment. In Section N-Medications, N0415 High Risk Drug Classes, the assessment reflected use and indication of anticoagulant medication, but no use or indication of antiplatelet medication. Record review of Resident #2's Care Plan Report initiated on 11/25/2025, and printed on 12/11/2025, reflected the Problem: [Resident #2] is on anticoagulant therapy r/t Disease process HX of CVA It reflected The Goal: The resident will be free from discomfort or adverse reactions related to anticoagulant use through the review date. It also reflected Interventions: Administer ANTICOAGULANT medications as ordered by the physician. Monitor for side effects and effectiveness Q-SHIFT. Monitor/document/report PRN adverse reactions of ANTICOAGULANT therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB, loss of appetite, sudden changes in mental status, significant or sudden changes in v/s. Observation and interview of Resident #2 on 12/9/2025 at 2:13 PM, revealed the resident to be clean and comfortable with no distress noted. The resident expressed no concerns, and no obvious concerns were noted. In an interview with DON on 12/11/2025 at 3:47 PM, DON stated that she could not speak on MDS assessments and referred the surveyor to the MDS Coordinators. In an interview with ADON on 12/11/2025 at 3:47 PM, ADON stated that she was not comfortable speaking on the process of conducting and coding MDS assessments and deferred to the MDS Coordinators. In an interview on 12/11/2025 at 4:01 PM, MDS A stated that she had been employed as an MDS Coordinator with the facility for 1 year. Prior to her employment with the facility, she was employed with a sister facility as an MDS Coordinator. MDS A stated that she had eighteen years of experience with the MDS process. MDS A stated that the MDS should accurately reflect the resident's needs, including proper classification of medications the resident was taking. MDS A stated that the use of antiplatelet medications should be indicated on the MDS if ordered. MDS A stated that the MDS should not reflect the use of an anticoagulant medication if one was not used or ordered. MDS A stated that she coded Resident #2's MDS incorrectly and that was an oversight on her part, not her regular practice. MDS A stated that she consulted the RAI manual if she had questions and for updated information. MDS A stated that she also utilized co-workers with knowledge and experience with the MDS process. MDS A stated that a possible negative outcome from miscoding MDS assessments would be that the OIG would discover the mistake and reduce reimbursements for services. MDS A stated in this case, no real harm came of the mistake because the outcomes are the same for both anticoagulant and antiplatelet medications. MDS A stated that a correction of Resident #2's MDS (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would be initiated by her immediately. MDS A stated that she had been trained and educated on the MDS process and regularly received in-service and ongoing training as updates were available. MDS A stated that she felt supported by management and other staff in her role. In an interview on 12/11/2025 at 4:01 PM, MDS B stated that she had been employed with this the facility since February 2025. MDS B stated that she had 10 years of experience with the MDS assessment process. MDS B stated that the MDS should accurately reflect the resident's needs, including proper classification of medications the resident was taking. MDS B stated that the use of antiplatelet medications should have been indicated on the MDS if ordered. MDS B stated that the MDS should not have reflected the use of an anticoagulant medication if one is was not used or ordered. MDS B stated they utilized ZPAX (an auditing software) to check the accuracy of their assessment submissions. This system alerted if something was possibly miscoded. Also, MDS B stated that they utilized other staff and the RAI manual when questions arise arose regarding the MDS process. MDS B stated that she had received proper education and training on the MDS process and felt supported by management and staff. In an interview on 12/11/2025 at 4:10 PM, CNO stated that MDS Coordinators received regular training and updates on the MDS process, and they utilized software that assisted in auditing the accuracy of MDS entries. The CNO also stated that MDS Coordinators had access to a staff member who was is considered a person of advanced knowledge regarding the MDS process. The staff member also audited submissions to ensure accuracy of MDS assessments. The CNO deferred to the MDS Coordinators for specific impact and outcomes this type of error may have had on residents. In an interview on 12/11/2025 at 4:10 PM, ADM stated MDS Coordinators were responsible for correct coding and data entry. ADM stated that miscoded assessments could have had an impact on how care needs are were reflected in residents' care plans. The ADM deferred to MDS Coordinators regarding specific MDS process related questions. Record review of the facility's policy on Comprehensive Assessments, Revised March 2022, reflected, Comprehensive assessments are conducted to assist in developing person-centered care plans. 1. Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual. 10. Comprehensive assessments are conducted and coordinated by a registered nurse with appropriate participation of other health professionals on the interdisciplinary team. Record review of the Long-Term Care Facility RAI 3.0 User's Manual last revised October 2024 reflected, The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that: (1) the assessment accurately reflects the resident's status		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 1 (Residents #5) of 8 residents reviewed for care plans. The facility failed to ensure Resident #5's nutritional status and needs, including orders for a puree diet and orders for thickened liquids, were addressed in the comprehensive care plan. This failure could place the resident at risk of not receiving necessary care or receiving incorrect care and services related to their identified needs to maintain or reach their highest practicable physical, mental, and psychosocial wellbeing. Record review of Resident #5's admission record printed on 12/11/2025 reflected an [AGE] year-old male admitted on [DATE]. Diagnoses included: other acute Osteomyelitis, left ankle and foot (an infection in a bone), memory deficit following cerebral infarction (problems with memory and thinking following a stroke), Dysphagia following cerebral infarction (difficulty swallowing following a stroke), and Dysphagia, Oropharyngeal Phase (difficulty in initiating a swallow leading to challenges in eating and drinking). Record review of Resident #5's comprehensive MDS assessment dated [DATE] reflected a BIMS score of 14 indicating moderate cognitive impairment. Section K indicated signs and symptoms of a possible swallowing disorder, including holding food in mouth/cheeks or residual food in mouth after meals, coughing or choking during meals or when swallowing medications, and complaints of difficulty or pain with swallowing. Section K indicated the resident was on a mechanically altered diet (pureed food, thickened liquids) on admission and while a resident. Section V-Care Area Assessment (CAA) Summary indicated that the Nutritional Status care area was triggered and was addressed in the care plan and that information related to this care area could be found in the diet order. Record review of Resident #5's Physician's Orders reflected an order dated 11/1/2025 which revealed, Regular diet Pureed texture, Nectar consistency. Record review of Resident #5's Physician's Orders reflected an order dated 12/10/2025 which revealed, Speech Therapy to re-eval for possible advance diet. Record review of Resident #5's Care Plan Report on 12/11/2025, reflected no Focus areas, Goals, or Interventions/Tasks related to the resident's nutritional status, including his swallowing disorder and mechanically altered diet. In an observation and interview of Resident #5 on 12/11/2025 at 11:00 AM, Resident #5 stated he was on a puree and thickened liquid diet and had been since admission. Resident #5 stated that he is concerned about his recent weight loss, and he attributed his weight loss to his puree diet solely. Resident #5 stated that he does not care for drinking thickened liquids either. The resident stated that OT had been monitoring his swallowing for the last 2 days prior in hopes in consideration of upgrading the consistency of his diet. The resident stated that a swallow study was being conducted that afternoon at 1 PM. The resident stated that he had no concerns about the care he received in the facility, and his needs were being met. He stated that he is impressed with the staff of the facility, and he was treated well. He stated that he felt included in his treatment planning and process and was kept up to date with services and treatments provided. In an interview on 12/11/2025 at 11:27 AM, RN C stated that she has had been employed with the facility since April 2025. She stated that resident care was good here and she has had no concerns for the treatment and care of residents. RN C stated that today it was her first time caring for Resident #5, so she was not as familiar with the resident as she was with others. RN C stated that all pertinent care information can be found in the resident's care plan and it was also shared during report at shift change. RN C stated if a resident was on an altered diet and thickened liquids, this that would need to be included in the resident's care plan. RN C said this that it was important to know so that the resident it was not provided with something that could make him choke, such as giving medications with regular water. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN C stated that she had been told during report that Resident #5 was on thickened liquids. RN C stated that she feels felt information in the care plans was usually accurate and comprehensive. RN C stated that she had received orientation, education, and regular in-service to effectively do her job. RN C stated that she feels felt supported by management and staff at the facility. In an interview on 12/11/2025 at 3:47 PM, DON stated that she is was currently the interim DON and has had been since July 2025. Prior to assuming the DON position, she was an ADON at the facility since June 2024. The DON stated the creation and revision of care plans is was a team effort. The DON stated that care plans should reflect the care and needs of the resident based on the assessment and doctor's orders. The DON stated that care plans are not the only source of information available to staff in determining a resident's care and needs, and care plans should not be the only information staff should rely on. In an interview on 12/11/2025 at 3:37 PM, ADON stated that she has been employed with the facility since April 2021. She was previously a floor nurse, wound care nurse, and staffing nurse. She stated when providing clinical care to a resident, the entire clinical picture and documents were considered. She stated that a care plan that doesn't completely address a resident's condition or physician's orders doesn't necessarily mean the resident's needs were not addressed or met. The ADON confirmed that Resident #5's diet and supplements were not care planned and should have been. The ADON stated it is important that care plans are were accurate and inclusive of all care needs to make sure the residents get got all the care necessary to meet their needs. The ADON stated there would have been no negative impact on the resident if their care plan was not complete and accurate because that it was not the only source of information available to staff. The ADON stated that staff are were not to solely rely on care plans to get the full clinical picture of the residents. In an interview with the CNO on 12/11/2025 at 4:10 PM, the CNO stated that care plans are considered living documents and should accurately reflect the resident's clinical picture; but care plans aren't the only source of information that staff rely on to provide for the needs of the residents. The CNO stated that her expectation would be that care plans are all inclusive In an interview with the ADM on 12/11/2025 at 4:10 PM, the ADM stated that their MDS Coordinators were responsible for ensuring the correct information it was included in residents' care plans. The ADM stated that it was his expectation that care plans would accurately reflected residents' care needs. ADM agreed that care plans aren't the only source of information that staff relied on to provide for the needs of residents, therefore, there was limited negative impact on the residents. Record review of the facility's policy regarding Care Plans, Comprehensive Person Centered, Revised December 2016, reflected, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 8. The comprehensive, person-centered care plan will: b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being; .g Incorporate identified problem areas.h. Incorporate risk factors associated with identified problems.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that drugs and biologicals used in the facility were stored properly for 1 of 1 medication storage room reviewed for drug storage. The facility failed to ensure expired lab supplies and needles used for biologicals were removed from the medication storage room. This failure could place residents at risk for inaccurate diagnoses from defective labs, ineffective treatments and unnecessary infections. Findings include: Observation on [DATE] at 2:58 PM of the Medication Storage room revealed: 5 Culture Swabs expired [DATE] 2 Blue Top Lab Tubes expired [DATE] 1 Lab Transport Tube expired [DATE] 4 Gold Top Lab Tubes expired [DATE] 4 Red Top Lab Tubes expired [DATE] 10 Precision Glide Needles expired [DATE] In an interview on [DATE] at 9:33 AM RN A stated the policy for expired medication supplies was to get rid of them. She stated that it was important not to use expired supplies for treatments and medications because it may not be safe. She stated if expired lab tubes, lab swabs, or needles were accidentally used, the residents could have inaccurate lab results and that could cause a wrong diagnosis and wrong medications for their condition. In an interview on [DATE] at 9:50 AM LVN D stated the policy for expired medication supplies was to let the DON know so she could discard them. She stated it was important not to use expired supplies for treatments and medications because the potency may not be good, and it may not work correctly. She stated if expired lab tubes, lab swabs, or needles were accidentally used, the resident could have a false positive or false elevated lab. She stated that if labs were incorrect, that could cause the doctor to treat the resident for something they do not have or not to treat for something they did have, and they could get septic (severe infection). In an interview on [DATE] at 9:58 AM CNA E stated the policy for expired supplies was to get rid of them and make sure they were taken out of circulation. She stated it was important not to use expired supplies because they may not be effective. In an interview on [DATE] at 10:10 AM MA G stated, the policy for expired medication supplies was to report and remove them. She stated it was important to not use expired supplies for treatments and medications because they may not be good anymore. She stated, if expired lab tubes, lab swabs, or needles were accidentally used, the resident could get contaminated which could result in an infection. In an interview on [DATE] at 10:28 AM the CNO stated the policy for expired medication supplies was to remove them from the pharmacy to destroy and medical supplies were thrown out. She stated it was important not to use expired supplies for treatments and medications because they could be faulty. She stated if expired lab tubes, lab swabs, or needles were accidentally used, the resident could get inaccurate lab results. She stated inaccurate lab results could cause the doctor to miss elevated lab results and result in incorrect treatments. She stated an example was if they missed elevated [NAME] Blood Cells they would not be able to treat and start antibiotics timely. Record Review of the facility Medication Labeling and Storage policy dated 2001 and revised 2023 reflected: The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. If the facility has outdated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interviews, and record review, the facility failed to prepare food by methods that conserve nutritive value and flavor for pureed diets for 1 of 1 kitchen reviewed for food and nutrition services. The facility failed to ensure DS B refrained from adding water to spaghetti pureed meals during lunch service on 12/9/2025. This failure could place residents who received a puree diet at risk for diminished or altered nutritional status and potential weight loss. Observation on 12/9/2023 at 11:14 AM revealed DS B poured water into the spaghetti noodles and sauce to assist in achieving the proper puree consistency. Observation on 12/9/2025 at 11:15 AM revealed DS A correcting DS B in her use of water for puree meals and instructed DS B to use broth. DS A was observed checking the consistency of the puree and advised DS B to continue using the food processor to achieve a smooth consistency. In an interview on 12/9/2025 at 11:16 AM, DS B stated that she returned to the facility several months ago as the cook but worked at the facility for some time prior. DS B stated that she had years of cumulative experience in the kitchen and as a cook in facilities and elsewhere. DS B stated that she had the proper training and education to do her job at the facility. DS B stated that she felt supported by her supervisor and management and received the things she needed to do her job well. DS B stated that her use of water instead of milk, broth, or melted butter was a mistake. DS B stated that she got nervous and grabbed for the water, but realized it was a mistake immediately after she poured it. DS B stated that she never used water for puree dishes. DS B stated that she understood that the use of water removes nutritive value of the food. In an interview on 12/9/2025 at 11:17 AM, DS A stated that she had been promoted to Dietary Supervisor several months ago. She stated that she had years of experience in the kitchen. She stated that she felt she had the training, education and experience needed to effectively do her job. She stated that her employees in the kitchen were properly trained and educated in proper kitchen practices as well. She agreed that water should not be used to puree dishes. Instead, DS A suggested broth be used in the dish to achieve the puree consistency, preserve the nutritive value of the food, and preserve the taste of the dish. DS A stated that the kitchen utilizes puree recipes that should be followed. DS A stated that she does not feel staff are not trained on the process. DS A stated that she agreed that DS B acted out of haste and nervousness, but that is not her usual practice. DS A corrected the puree dish and reinforced with DS B the importance of the use of proper liquids. DS A stated that DS B is her lead kitchen personnel, and she has always managed the kitchen well with no concerns noted by DS A or others. In an interview on 12/11/2025 at 4:10 PM, the ADM stated that his expectation regarding pureed foods is that staff will follow recipes and not go from memory. The ADM stated that he had no concerns that kitchen staff lacked proper training or experience in the kitchen to conduct tasks such as pureeing food. The ADM stated that there had been no problems noted or reported with pureed foods in the past. The ADM stated that he had no concerns that the use of water in pureed foods negatively impacted the residents. The ADM stated that the only negative aspects of using water to puree food would have been how it affected the taste only. The ADM disagreed that the use of water in puree would reduce the nutritive value of the food. In an interview on 12/11/2025 at 4:10 PM, the CNO stated her expectation regarding pureed foods would have been that staff would have followed approved recipes. The CNO stated using water to puree foods produced no negative impact other than possibly reducing the salt or seasoning of the dish. The CNO stated that kitchen staff typically used broth or other flavored liquids in the puree process, but DS B got nervous and used water. The CNO stated that was not their typical process. The CNO denied the use of water reduced the nutritive value of the food because the dish still contained all the same main ingredients. Record review of the facility's Pureed Foods Guidelines provided by DS A on 12/11/2025 at 3PM reflected the following in part: To prepare pureed foods: 3. Add appropriate liquid (ex: reserved liquid, broth, juice, milk), if needed, to assist with pureeing. A chart also listed examples of liquid to use for different pureed foods (subject to diet order). Water was not listed. It was also noted that the sauce or gravy used should complement the dish being pureed.		