

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Ridgecrest Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 561 E Ridgecrest Rd Forney, TX 75126	

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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879</p> <p>Based on interviews and record review, the facility failed to implement written policies and procedures to prohibit and prevent abuse, neglect, and misappropriation for 1 of 10 residents (Resident #1) reviewed for developing and implementing abuse policies.</p> <p>The facility failed to follow its policy to report to the Texas Health and Human Services Commission (HHSC) when Resident #1 alleged that LVN B did not do her treatment on 03/21/25 and she felt neglected.</p> <p>The facility staff did not report to the state agency that Resident #1 felt neglected by her missed wound treatment on 03/21/25.</p> <p>This failure could place residents at risk of neglect, abuse, mental anguish, and emotional distress.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, dated 03/27/25, indicated an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included arthritis (conditions that cause joint pain, swelling, and stiffness), diabetes(is a chronic condition that happens when you have persistently high blood sugar levels), anxiety(characterized by excessive and persistent worry, fear, and nervousness) and dementia(diseases that affect memory, thinking, and the ability to perform daily activities).</p> <p>Record review of Resident #1's quarterly MDS assessment, dated 01/26/25, indicated Resident #1 understood and was understood by others. Resident #1's BIMS score was 14, which meant she was cognitively intact. The MDS indicated Resident #1 required help with toileting, bed mobility, dressing, transfers, personal hygiene, and independent with eating. The MDS indicated Resident #1 had an open lesion, and it required treatment.</p> <p>Record review of Resident #1's care plan revised on 06/11/24 indicated Resident #1 had an actual impairment to her skin integrity to the left axilla related to an open area where her humerus repair hardware had broken through the skin. The intervention was for staff to follow the facility protocol for treating the injury.</p> <p>(continued on next page)</p>

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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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's physician's orders dated 03/03/25, indicated, Clean left axilla (the area on the human body directly under the shoulder joint) with normal saline, pay dry, apply silver gel, calcium alginate, and cover with bordered gauze every day shift every Monday, Wednesday, and Friday for metal piece sticking out of left axilla.</p> <p>Record review of Resident #1's medication Administration Record on 03/21/25 for Clean left axilla with normal saline, pay dry, apply silver gel, calcium alginate, and cover with bordered gauze every day shift every Monday, Wednesday, and Friday for metal piece sticking out of left axilla was not signed out as being done.</p> <p>During an interview on 03/24/25 at 12:30 p.m., Resident #1 said she did not have her treatment done on Friday (03/21/25) by LVN B. She said she had asked an unknown staff member to tell the nurse, but the nurse never came. She said she felt neglected and was upset because she had to wait until the next day to have her treatment done.</p> <p>During a phone interview on 03/25/25 at 2:10 p.m., LVN C said on Saturday 03/22/25, Resident #1 said she did not get her treatment done on Friday and had asked for it to be done. LVN C said Resident #1 said she felt neglected because her treatment was not done. LVN C said Resident #1's treatment was supposed to be done on Friday (03/21/25). LVN C said she did Resident #1's treatment on Saturday (03/22/25) but did not tell the abuse coordinator or DON about Resident #1 making the allegation of neglect. She said she had been trained on reporting abuse and should have reported it to the Administrator. She said it was a busy day and forgot to report it.</p> <p>During a phone interview on 03/25/25 at 4:10 p.m., LVN B said Resident #1's treatment was due on Friday (03/21/25), but she was unaware the treatment had not been done. She said they usually had a treatment nurse Monday through Friday and did not realize the treatment nurse was off on Friday (03/21/25). She said the DON had sent a text indicating that the treatment nurse was off and for the nurses to do the treatments, but she said she did not see the text until questioned by the surveyor. LVN B said she did not do Resident #1's scheduled treatment on Friday (03/21/25).</p> <p>During an interview on 03/26/25 at 3:03 p.m., the DON said she expected staff to do treatments as ordered. She said on Friday (03/21/25), the treatment nurse had called off, and she sent a mass text to the nurses letting them know to do the treatments. She said she was unaware Resident #1's treatment was not done until the surveyor reported it to the Administrator on 03/24/25. She said Resident #1's treatment should have been done as ordered. She said she was not aware Resident #1 made the neglect allegation until yesterday (03/25/25) when LVN C called and reported to the Administrator that Resident #1 felt neglected because her treatment was not done. The DON said LVN C should have reported Resident #1, making the allegation of neglect. She said she had LVN C come to the facility and write her statement. She said they have done several in-services on neglect/abuse. The DON said it was important to report and investigate abuse/neglect to prevent further abuse/neglect from occurring.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/26/25 at 4:37 p.m., the Administrator said he was unaware Resident #1 did not get her treatment done on (03/21/25) until the surveyor informed him of her allegation on 03/24/25. The Administrator said he went to talk to Resident #1, and she told him LVN B did not do her treatment on (03/21/25) and she felt neglected. The Administrator said he reported to HHSC, suspended LVN B, started his internal investigation, and staff was in-serviced on abuse/neglect. He said he learned yesterday (03/25/25) that LVN C was aware of Resident #1's neglect allegation but did not report it to him. He said the staff was aware that he was the abuse coordinator and should have reported the allegation of neglect to him. He said any allegation of abuse/neglect should have been reported to him, and his responsibility was to protect the residents, suspend the alleged perpetrator, and report to HHSC within 2 hours. He said the DON/ADON oversaw the process of treatments being done. He said part of their plan of correction was they came up with a back-up plan for when/or if the treatment nurse called off. The Administrator said when allegations were not reported promptly, abuse could continue to occur, and residents could be in danger if the abuse/neglect was continuing.</p> <p>Record review of the facility's Inservice dated 03/24/24 revealed staff were trained on abuse and neglect, exploitation, what abuse and neglect were, and who to report abuse and neglect to. The in-service was conducted by the ADON</p> <p>Record Review of 12 safe surveys conducted by the facility social worker did not reveal any additional concerns.</p> <p>Record review of the facility policy titled Abuse Prohibition Policy, revised 05/17/24, indicated, Intent: This protocol was intended to assist in the prevention of abuse, neglect, and misappropriation of property. Each resident has the right to be free from abuse, mistreatment, neglect, corporal punishment, voluntary seclusion, and financial abuse. Policy: The facility will prohibit neglect and mental or physical abuse, including involuntary seclusion and misappropriation of property. #2 The facility will investigate alleged or suspected abuse, neglect, or misappropriation of property and will provide notification of information to the proper authorities according to state and federal regulations. Reporting: Any employee who becomes aware of an allegation of abuse, neglect, or misappropriation of resident property shall report the incident to the abuse coordinator immediately. The abuse coordinator will report all allegations of abuse, neglect with serious bodily injury, mistreatment with serious bodily injury, and injury of unknown source with bodily injury immediately or within two hours of the allegation. The abuse coordinator reports all other allegations of neglect, mistreatment, exploitation, injuries of unknown source, and misappropriation within 24 hours of the allegation.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879</p> <p>Based on interview, and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 2 (Resident #1) residents reviewed for quality of care.</p> <p>The facility failed to ensure that LVN B did Resident #1's left axilla wound treatment as ordered on 03/21/25.</p> <p>This failure could result in residents with wounds not having their treatments performed as ordered, wounds becoming infected, and decreased wound healing.</p> <p>Findings Included:</p> <p>Record review of Resident #1's face sheet, dated 03/27/25, indicated an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included arthritis (conditions that cause joint pain, swelling, and stiffness), diabetes(is a chronic condition that happens when you have persistently high blood sugar levels), anxiety(characterized by excessive and persistent worry, fear, and nervousness) and dementia(diseases that affect memory, thinking, and the ability to perform daily activities).</p> <p>Record review of Resident #1's quarterly MDS assessment, dated 01/26/25, indicated Resident #1 understood and was understood by others. Resident #1's BIMS score was 14, which meant she was cognitively intact. The MDS indicated Resident #1 required help with toileting, bed mobility, dressing, transfers, and personal hygiene, and was independent with eating. The MDS indicated Resident #1 had an open lesion, and it required treatment.</p> <p>Record review of Resident #1's physician's orders dated 09/23/23 indicated to monitor the left axilla metal rod every shift for signs and symptoms of infection.</p> <p>Record review of Resident #1's physician's orders dated 03/03/25, indicated, Clean left axilla (the area on the human body directly under the shoulder joint) with normal saline, pay dry, apply silver gel, calcium alginate, and cover with bordered gauze every day shift every Monday, Wednesday, and Friday for metal piece sticking out of left axilla.</p> <p>Record review of Resident #1's care plan revised on 06/11/24 indicated Resident #1 had an actual impairment to her skin integrity to the left axilla related to an open area where her humerus repair hardware had broken through the skin. The intervention was for staff to follow the facility protocol for treating the injury and monitor the left axilla metal rod.</p> <p>Record review of Resident #1's medication Administration Record on 03/21/25 for Clean left axilla with normal saline, pay dry, apply silver gel, calcium alginate, and cover with bordered gauze every day shift every Monday, Wednesday, and Friday for metal piece sticking out of left axilla was not signed out as being done.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/24/25 at 12:30 p.m., Resident #1 said she did not have her treatment done on Friday (03/21/25) by LVN B. She said she had asked an unknown staff member to tell the nurse, but the nurse never came.</p> <p>During a phone interview on 03/25/25 at 4:10 p.m., LVN B said Resident #1's treatment was due on Friday (03/21/25), but she was unaware the treatment had not been done. She said they usually had a treatment nurse Monday through Friday and did not realize the treatment nurse was off on Friday (03/21/25). She said the DON had sent a text indicating that the treatment nurse was off and for the nurses to do the treatments, but she said she did not see the text until questioned by the surveyor. LVN B said she could not remember if she looked at Resident # 1's left axilla wound on Friday to see if it had any signs of infection. LVN B said she did not look at Resident #1's treatment MAR on Friday (03/21/25) because she did not know she needed to. She said she was responsible for the medications and thought the treatment nurse had done her treatment. LVN B said she did not do Resident #1's scheduled treatment on Friday (03/21/25).</p> <p>During an interview on 03/26/25 at 3:03 p.m., the DON said she expected staff to do treatments as ordered. She said on Friday (03/21/25), the treatment nurse had called off, and she sent a mass text to the nurses letting them know to do the treatments. She said she was unaware Resident #1's treatment was not done till the surveyor reported it to the Administrator on 03/24/25. She said Resident #1's treatment should have been done as ordered. The DON said the importance of following the wound care physician's orders was for wound healing and prevention of infection.</p> <p>During an interview on 03/26/25 at 4:37 p.m., the Administrator said he was unaware Resident #1 did not get her treatment done on (03/21/25) until the surveyor informed him of her allegation on 03/24/25. The Administrator said he went to talk to Resident #1, and she told him LVN B did not do her treatment on (03/21/25). The Administrator said he expected staff to follow the physician's orders to promote wound healing.</p> <p>Record review of the facility's policy titled Skin Integrity Prevention and Treatment Program, revised 1/2023, indicated, . Wound Care: C Adheres to infection control best practice.</p> <p>Record review of the facility policy titled Abuse Prohibition Policy, revised 05/17/24, indicated, Intent: This protocol was intended to assist in the prevention of abuse, neglect, and misappropriation of property. Each resident has the right to be free from abuse, mistreatment, neglect, corporal punishment, voluntary seclusion, and financial abuse. Policy: The facility will prohibit neglect and mental or physical abuse .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47612</p> <p>Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 2 of 21 residents (Resident #1 and Resident #2) reviewed for infection control.</p> <p>1. The facility failed to ensure CNA D and CNA E wore PPE while providing catheter care on Resident #2 on 03/26/25.</p> <p>2. The facility failed to ensure LVN A wore the proper PPE (gown and gloves), changed her gloves, and performed hand hygiene while performing wound care on Resident #1 on 03/25/25.</p> <p>These failures could place residents and staff at risk for cross-contamination and spread of infection and could potentially affect all others in the building.</p> <p>Findings Include:</p> <p>1. Record review of a face sheet dated 03/26/25, indicated Resident #2 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of chronic kidney disease (your kidneys exhibit mild damage, indicated by a slightly reduced estimated glomerular filtration rate), retention of urine (the inability to completely empty the bladder, either acutely (suddenly) or chronically (gradually)), benign prostatic hyperplasia with lower urinary tract symptoms (prostate gland was growing, putting pressure on the urethra and bladder, causing urinary problems like frequent urination, weak stream, and difficulty emptying the bladder).</p> <p>Record review of Resident 2's admission MDS assessment, dated 03/07/25, indicated Resident #2 understood and was understood by others. Resident #2's BIMS score was 15 indicating he was cognitively intact. The MDS indicated Resident #2 required assistance with his transfers, toileting, dressing, hygiene, and set up for eating. The MDS indicated he had an indwelling catheter.</p> <p>Record review of Resident #2's care plan dated 03/03/25, did not indicate enhanced barrier precaution.</p> <p>Record review of Resident #2's order summary dated 03/26/25, indicated foley catheter care every shift and as needed, with a start date of 03/02/2025.</p> <p>During an observation on 03/26/25 at 10:45 a.m., CNA D and CNA E performed catheter care on Resident #2. They both had on gloves but did not have on a gown as part of the appropriate PPE. This surveyor observed no enhance barrier precaution sign on the door or PPE at the door.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/26/25 at 1:30 p.m., RN F stated she did not know what happened to the enhanced barrier precaution sign and PPE, it was at the door the day before. RN F stated it was the nurse's responsibility to make sure the enhanced barrier precaution sign and PPE was at the door. RN F stated if the CNAs were unsure if they needed to wear PPE for a resident with a catheter they should have asked the nurse. RN F stated it was important to use PPE for a resident with a catheter to prevent infection.</p> <p>During an interview on 03/26/25 at 1:38 p.m., CNA D stated she should have asked the nurse if she needed to wear a gown during catheter care. CNA D stated it was important to wear the appropriate PPE during catheter care to prevent the spread of infection. CNA D stated the harm to the resident could be urinary tract infection.</p> <p>During an interview on 03/26/25 at 1:42 p.m., CNA E stated she should have asked the nurse if Resident #2 was in enhanced barrier precautions since he had a catheter. CNA E stated it was important for residents with a catheter to be in enhance barrier precaution, so the resident did not get an infection. CNA E stated the harm of providing catheter care without wearing a gown either the staff or the resident could be exposed to an infection.</p> <p>During an interview on 03/26/25 at 3:00 p.m., the DON stated all of the nursing staff was responsible for ensuring a enhanced barrier precautions sign and PPE was at the residents door and the staff knew to wear PPE while preforming care. The DON stated enhanced barrier precautions were important to keep from passing bacteria. The DON stated the harm to the resident was infection. The DON stated the staff was in-serviced on enhanced barrier precautions as needed, on hire, and annually.</p> <p>During an interview on 03/26/25 at 3:30 p.m., the Administrator stated he expected all staff to follow the guidelines on the sign posted on the door. The Administrator stated the staff was aware of Resident #2 in enhanced barrier precaution. The Administrator stated the sign on the door and the setup outside the door was there the day before. The Administrator stated he made routine rounds to ensure staff was following the guidelines and the DON had given several in-services on enhanced barrier precautions. The Administrator stated the staff should be wearing the proper PPE (gown and gloves) to protect themselves and to keep the spread of infection from other residents.</p> <p>45879</p> <p>2.Record review of Resident #1's face sheet, dated 03/27/25, indicated an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included arthritis (conditions that cause joint pain, swelling, and stiffness), diabetes (is a chronic condition that happens when you have persistently high blood sugar levels), anxiety (characterized by excessive and persistent worry, fear, and nervousness) and dementia (diseases that affect memory, thinking, and the ability to perform daily activities).</p> <p>Record review of Resident #1's quarterly MDS assessment, dated 01/26/25, indicated Resident #1 understood and was understood by others. Resident #1's BIMS score was 14, which meant she was cognitively intact. The MDS indicated Resident #1 required help with toileting, bed mobility, dressing, transfers, and personal hygiene, and was independent with eating. The MDS indicated Resident #1 had an open lesion, and it required treatment.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's physician's orders dated 03/03/25, indicated, Clean left axilla (the area on the human body directly under the shoulder joint) with normal saline, pay dry, apply silver gel, calcium alginate, and cover with bordered gauze every day shift every Monday, Wednesday, and Friday for metal piece sticking out of left axilla.</p> <p>Record review of Resident #1's care plan revised on 06/11/24 indicated Resident #1 had an actual impairment to her skin integrity to the left axilla related to an open area where her humerus repair hardware had broken through the skin. The intervention was for staff to follow the facility protocol for treating the injury.</p> <p>Record review of Resident #1's care plan dated 01/16/25 indicated Resident #1 required Enhanced Barrier Precautions, also known as EBP (infection control practices designed to reduce the spread of multidrug-resistant organisms (MDROs) in nursing homes by focusing on gown and glove use during high-contact resident care activities) related to her wound. The interventions were for staff to use EBP during high-contact resident care activities as applicable, such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, wound care (any skin opening requiring a dressing), and other areas determined to require EBP.</p> <p>During an observation on 03/24/25 at 12:30 p.m., an Enhanced Barrier Precautions sign and a cart were outside Resident #1's room.</p> <p>During an observation on 03/26/25 at 9:15 a.m., LVN A applied gloves, entered Resident #1's room to set up her supplies without a gown on, exited the room, and changed gloves without performing hand hygiene. LVN A re-entered Resident #1's room without a gown, applied gloves, and removed the dressing from Resident #1's left axilla. LVN B did not remove her gloves or perform hand hygiene before cleaning the wound to Resident #1's left axilla with normal saline. LVN A applied silver gel, calcium alginate, and a bordered dressing to Resident #1's left Axilla. LVN A did not change her gloves or perform hand hygiene, then gathered all her trash with the same dirty gloves, pulled up Resident #1's bed covers, and placed her bedside table over the bed.</p> <p>During an interview on 03/26/25 at 9:35 a.m., LVN A said she did not realize she did not change gloves or perform hand hygiene during the wound care for Resident #1. She said she should have changed her gloves and performed hand hygiene when going from dirty to clean to prevent infection in the wound. LVN A said she did not wear the proper PPE when entering Resident #1's room or while performing wound care. She said Resident #1 was on EBP, and she should have worn a gown and glove while in Resident #1's room to prevent the spread of infection.</p> <p>During an interview on 03/26/25 at 3:03 p.m., the DON said she expected staff to perform hand hygiene when they entered or exited a room, when visibly soiled, between dirty and clean, and between glove changes. The DON said the importance of hand hygiene was infection control. The DON said Resident #1 was on EBP, and when staff was in her room to perform care such as wound care, they should have on a gown and gloves to prevent infection.</p> <p>During an interview on 03/26/25 at 4:37 p.m., the Administrator said he expected staff to perform hand hygiene as needed, before and after providing care, in between care, and between glove changes. He said if Resident #1 was on EBP and the nurse was performing wound care, the nurse should have had on a gown and gloves. The Administrator said the importance of hand hygiene and following EBP was infection prevention and cross-contamination.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's policy titled Infection Prevention and Control, revised date of 03/18/25, indicated Policy statement: an infection prevention and control program is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>Record review of the facility's policy titled Handwashing-Hand Hygiene, revised date of 10/2020, indicated, Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: #2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. #7. Use an alcohol-based hand rub containing at least 62% alcohol or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: g. Before handling clean or soiled dressings, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident care; k. After handling used dressings, contaminated equipment, etc.; #10. Hand hygiene is recognized as the best practice for preventing healthcare-associated infections.</p> <p>Record review of the facility's policy titled Enhanced Barrier Precautions, dated 04/01/24, indicated Enhanced Barrier Precautions for residents with any of the following: wounds and indwelling medical devices even if the resident was not known to be infected Indwelling medical device example include central lines, urinary catheters, feeding tubes, and tracheostomies</p>