STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676275	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgecrest Healthcare and Rehabilitation Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure in accordance with professional standards of practices, the medical records on each resident were accurately documented for 1 of 7 residents (Resident #1) reviewed for accurate medical records. The facility failed to ensure a pulse and blood pressure was not recorded for Resident #1 on 3/26/26 when she was discharged to the hospital on 3/25/26 and had not returned to the facility. The facility failed to ensure the ADON charted the correctly dated vital signs on skilled nursing notes for Resident #1 on 3/22/26, 3/23/26, and 3/24/26. The facility failed to ensure the ADON did not chart skilled nursing notes on Resident #1 on 3 days (3/26/26, 3/27/26, and 3/28/26) after she had been admitted to the hospital. These failures could place residents at risk for inaccurate assessments, monitoring, and for not being provided proper care due to inaccurate documentation.Findings included: Record review of the face sheet dated 4/14/26 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE]. Record review of the Diagnoses Report dated 4/14/25 indicated Resident #1 had diagnoses including seizures (temporary, uncontrolled surges of electrical activity in the brain that disrupts normal function), schizoaffective disorder (a chronic mental health condition characterized by a combination of schizophrenia and mood disorder), hypertensive heart disease (refers to heart damage including thickened muscles, coronary artery disease, and heart failure caused by long-term unmanaged high blood pressure), diabetes, and hypertension (elevated blood pressure). Record review of the MDS dated [DATE] indicated Resident #1 understood others and was usually understood by others. The MDS indicated Resident #1 had a BIMS score of 03 and severely cognitively impaired. The MDS indicated Resident #1 was dependent on staff for transfers. Record review of the care plan initiated 3/3/26 indicated Resident #1 had an ADL self-care deficit. Record review of the weights and vitals summary dated 4/14/26 indicated Resident #1 had a blood pressure of 103/60 on 3/26/26 and a pulse of 100 on 3/26/26. Record review of daily nursing charting skilled note dated 3/22/26 and completed by the ADON indicated Resident #1 had a blood pressure of 103/60 on 3/26/25, temperature of 98.4 on 3/25/26, pulse of 100 on 3/26/26, a respiration rate of 17 breath per minute on 3/25/26, and an oxygen saturation (the measure of oxygen-carrying hemoglobin (an iron rich protein in red blood cells) in the blood) of 96% on 3/25/26. Record review of daily nursing charting skilled note dated 3/23/26 and completed by the ADON indicated Resident #1 had a blood pressure of 103/60 on 3/26/25, temperature of 98.4 on 3/25/26, pulse of 100 on 3/26/26, a respiration rate of 17 breath per minute on 3/25/26, and an oxygen saturation of 96% on 3/25/26. Record review of daily nursing charting skilled note dated 3/24/26 and completed by the ADON indicated Resident #1 had a blood pressure of 103/60 on 3/26/25, temperature of 98.4 on 3/25/26, pulse of 100 on 3/26/26, a respiration rate of 17 breath per minute on 3/25/26, and an oxygen saturation of 96% on 3/25/26. Record review of the SBAR (situation, background, assessment, and recommendation) report dated 3/25/26 indicated Resident #1 was transferred to the ER due to a change in condition. Record review of daily nursing charting skilled note dated 3/26/26 and completed by the ADON indicated Resident #1 had a blood pressure of 103/60 on 3/26/25, temperature of 98.4 on 3/25/26, pulse of 100 on 3/26/26, a respiration rate of 17 breath (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676275	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgecrest Healthcare and Rehabilitation Center	561 E Ridgecrest Rd Forney, TX 75126

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	per minute on 3/25/26, and an oxygen saturation of 96% on 3/25/26. Record review of daily nursing charting skilled note dated 3/27/26 and completed by the ADON indicated Resident #1 had a blood pressure of 103/60 on 3/26/25, temperature of 98.4 on 3/25/26, pulse of 100 on 3/26/26, a respiration rate of 17 breath per minute on 3/25/26, and an oxygen saturation of 96% on 3/25/26. Record review of daily nursing charting skilled note dated 3/28/26 and completed by the ADON indicated Resident #1 had a blood pressure of 103/60 on 3/26/25, temperature of 98.4 on 3/25/26, pulse of 100 on 3/26/26, a respiration rate of 17 breath per minute on 3/25/26, and an oxygen saturation of 96% on 3/25/26. During an interview on 4/14/26 at 1:09 p.m. the ADON said she was familiar with Resident #1. The ADON said she did not know why there were skilled nurse's notes for 3 days after Resident #1 was admitted to the hospital. The ADON said she did assist the nurses with their skilled nurse charting on residents. The ADON said if skilled nurse notes were completed for 3 days after Resident #1 was sent to the hospital that it was an error. The ADON said vital signs on skilled nursing notes should be dated the same date as the nursing note. The ADON said if the vital signs were not the same as the date of the skilled nursing note it was an error. The ADON said vital sign recordings for Resident #1 dated after 3/25/26 were an error. The ADON said the importance of accurate documentation and dates was to have the information on a resident in real time. During an interview on 4/14/26 at 2:29 p.m. the DON said she expected charting to be done in real time with a short narrative in addition to check boxes on templates. The DON said the ADON was responsible for ensuring charting was accurate. The DON said it was her responsibility to ensure the ADON was checking resident charts for accuracy. The DON said she only had one ADON as the other one had been termed and it had caused them to get behind on things. The DON said she had failed to check the ADON's work due to working through her medication audits. The DON said the importance of accurate charting was provide proof of what had been done for a resident and when. Record review of the facility's Nursing Documentation Guideline dated 1/15/19 indicated, To ensure nursing document is accurate, timely, and reflective of the resident's clinical condition, while supporting efficient and appropriate documentation practices.Nursing documentation reflects the resident's clinical status and any significant findings or interventions, rather than duplicating information already captured elsewhere in the record.Documentation is completed as close to the time of care as practicable. Entries are accurate, objective, and resident specific. Duplicate of unnecessary documentation is avoided.