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	05/14/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents, 2 of 10 (Residents #1 and #2) reviewed for abuse. The facility did not ensure the Abuse Coordinator implemented their policy on reporting abuse to state agency for a resident-to-resident altercation that occurred on 11/09/25 between Resident #1 and Resident #2. This deficient practice could place residents at risk of unreported abuse, neglect, and a decreased quality of life. Findings include: Record review of the facility policy for Abuse Prohibition Policy, revised 02/26/26 reflected.each resident has the right to be free from abuse. Investigation: (2) The Abuse Coordinator will report such allegations to the state agency in accordance with state law.within two hours of the allegation.Resident #1 Record review of Resident #1's face sheet, dated 05/14/26, reflected Resident #1 was a [AGE] year-old male, admitted to the facility on [DATE] with a diagnosis which included cerebrovascular disease (a group of conditions that affect the blood flow and the blood vessels in the brain). Record review of Resident #1's quarterly MDS assessment, dated 04/30/26, reflected Resident #1 made himself understood and understood others. Resident #1's BIMS score was a 15, which reflected his cognition was intact. Resident #1 had no behaviors or refusal of care during the look-back period.Record review of Resident #1's comprehensive care plan revised on 11/24/25 reflected Resident #1 had a potential to be physically aggressive related to anger. The care plan interventions included on 11/09/25 the victim was removed from the aggressor, incident called into state, psych eval conducted as allowed and 1:1 supervision placed on resident. Resident #2Record review of Resident #2's face sheet, dated 05/14/26, reflected Resident #1 was a [AGE] year-old male, admitted to the facility on [DATE] with a diagnosis which included sepsis (condition in which the body responds improperly to an infection). Record review of Resident #2's admission MDS assessment, dated 11/06/25, reflected Resident #2 sometimes made himself understood and sometimes understood others. Resident #2's BIMS score was 0, which reflected his cognition was severely impaired. Resident #2 had no behaviors or refusal of care during the look-back period.Record review of Resident #2's comprehensive care plan, revised 11/21/25 reflected verbal aggression received and Resident #2 was removed from the aggressor and placed in another room. Record review of the PIR dated 11/13/25 reflected an allegation of resident-to-resident incident on Resident #1 and #2 that occurred on 11/09/25. The PIR reflected Resident #1 was witnessed by staff speaking in a loud tone toward Resident #2. Resident #1 stated he was frustrated and irritable due to difficulty sleeping since Resident #2 arrival, citing Resident #2 snoring and vocalization at night as contributed factor. The incident was reported to the state agency on 11/09/25 at 5:23 p.m.Record review of the verbal aggression incident report dated 11/09/25 at 9:00 a.m. reflected LVN A was in the resident's room administering Resident #2 a breathing treatment when a loud verbal altercation was heard from the hallway. Resident #1 was observed rolling inside the room with MA B walking behind him when Resident #1 appeared visibly agitated and shouting as he was rolling in the room. Resident #1 stopped by the foot of Resident #2 bed and stated, I am going to punch him while raising his fist. The DON was notified 9:25 a.m. and the Administrator was notified at 9:30 a.m. of the incident. During an interview on 05/13/26 at 9:04 a.m., Assistant Administrator C (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she learned of the incident 11/09/25 at 3:55 p.m. by the Administrator. Assistant Administrator C stated after she was notified, she initiated the self-report and submitted the information to the state of Texas by 5:23 PM. Assistant Administrator C stated during the investigation she started pulling progress notes and the incidents report, she noticed the incident occurred approximately 9:00 a.m. on 11/09/25. Assistant Administrator C stated she was told by the Administrator he was not sure if it was reportable or not, that was why she was not notified that morning. Assistant Administrator C stated when she initially reported the incident, she was taking the directions of the Administrator who was the abuse coordinator. Assistant Administrator C stated she was not sure if the incident needed to be reported or not because there were no lasting psychological effects. Assistant Administrator C stated abuse should be reported within two hours to HHSC either by her or the Administrator. Assistant Administrator C stated she monitored by daily management clinical rounds by speaking to the residents/family, any of their concerns or grievances were followed up immediately and reviewed the grievances during morning meeting and address any concerns. Assistant Administrator C stated it was important to report an allegation of abuse and neglect for safety and protection of the residents and try to prevent other incidents of abuse.During an interview on 05/14/26 at 3:00 p.m., the DON stated she was notified by the RN weekend supervisor the morning of the incident on 11/09/25. The DON stated she immediately notified the Abuse Coordinator, which was the Administrator right after the RN weekend supervisor notified her. During an interview on 05/14/26 at 3:40 p.m., the Administrator stated he was notified by the DON the morning of the incident. The Administrator stated he did not feel the incident was reportable at the time he was notified that morning, and then after later review with his corporate team, he determined it was reportable. The Administrator stated he was notified the resident was upset and yelling at Resident #2 and got close to his face but did not make any physical contact with him. The Administrator stated later he had spoken to the DON, and she felt the incident was a reportable event. The Administrator stated after speaking to the DON he contacted his corporate staff and all agreed that it should be reported to the state. The Administrator stated he notified Assistant Administrator C around 5:00 p.m. to tell her to initiate a reportable event. The Administrator stated this incident was considered verbal abuse. The Administrator stated he was not in a location that permitted him to report at that time, so he contacted Assistant Administrator C and asked her to report. The Administrator stated he monitored abuse by daily rounds and open conversations with residents/staff to ensure comfortability to report concerns to her. The Administrator stated it was important to report allegations of abuse for the safety of the residents to prevent further incidents.

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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 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 were reported immediately, but no later than 2 hours after the allegation was made, for 2 of 10 (Residents #1 and #2) residents reviewed for reporting. The facility did not report the resident-to-resident altercation between Resident #1 and Resident #2 to the State Survey Agency within 2 hours of been notified on 11/09/25. This failure to report could place the residents at risk for abuse. Findings include:Resident #1 Record review of Resident #1's face sheet, dated 05/14/26, reflected Resident #1 was a [AGE] year-old male, admitted to the facility on [DATE] with a diagnosis which included cerebrovascular disease (a group of conditions that affect the blood flow and the blood vessels in the brain). Record review of Resident #1's quarterly MDS assessment, dated 04/30/26, reflected Resident #1 made himself understood and understood others. Resident #1's BIMS score was a 15, which reflected his cognition was intact. Resident #1 had no behaviors or refusal of care during the look-back period.Record review of Resident #1's comprehensive care plan revised on 11/24/25 reflected Resident #1 had a potential to be physically aggressive related to anger. The care plan interventions included on 11/09/25 the victim was removed from the aggressor, incident called into state, psych eval conducted as allowed and 1:1 supervision placed on resident. Resident #2Record review of Resident #2's face sheet, dated 05/14/26, reflected Resident #1 was an [AGE] year-old male, admitted to the facility on [DATE] with a diagnosis which included sepsis (condition in which the body responds improperly to an infection). Record review of Resident #2's admission MDS assessment, dated 11/06/25, reflected Resident #2 sometimes made himself understood and sometimes understood others. Resident #2's BIMS score was 0, which reflected his cognition was severely impaired. Resident #2 had no behaviors or refusal of care during the look-back period.Record review of Resident #2's comprehensive care plan, revised 11/21/25 reflected verbal aggression received and Resident #2 was removed from the aggressor and placed in another room. Record review of the PIR dated 11/13/25 reflected an allegation of resident-to-resident incident on Resident #1 and #2 that occurred on 11/09/25. The PIR reflected Resident #1 was witnessed by staff speaking in a loud tone toward Resident #2. Resident #1 stated he was frustrated and irritable due to difficulty sleeping since Resident #2 arrival, citing Resident #2 snoring and vocalization at night as contributed factor. The incident was reported to the state agency on 11/09/25 at 5:23 p.m.Record review of the verbal aggression incident report dated 11/09/25 at 9:00 a.m. reflected LVN A was in the resident's room administering Resident #2 a breathing treatment when a loud verbal altercation was heard from the hallway. Resident #1 was observed rolling inside the room with MA B walking behind him when Resident #1 appeared visibly agitated and shouting as he was rolling in the room. Resident #1 stopped by the foot of Resident #2 bed and stated, I am going to punch him while raising his fist. The DON was notified 9:25 a.m. and the Administrator was notified at 9:30 a.m. of the incident. During an interview on 05/13/26 at 9:04 a.m., Assistant Administrator C stated she learned of the incident 11/09/25 at 3:55 p.m. by the Administrator. Assistant Administrator C stated after she was notified, she initiated the self-report and submitted the information to the state of Texas by 5:23 PM. Assistant Administrator C stated during the investigation, when she started pulling progress notes and incidents report she noticed the incident occurred approximately 9:00 a.m. on 11/09/25. Assistant Administrator C stated she was told by the Administrator he was not sure if it was reportable or not, that was why she was not notified that morning. Assistant Administrator stated when she initially reported the incident, she was taken direction of the Administrator who was the abuse coordinator. Assistant Administrator C stated she was not sure if the incident needed to be reported or not because there were no lasting psychological effects. Assistant Administrator C stated abuse should (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be reported within two hours to HHSC either by her or the Administrator. Assistant Administrator C stated she monitored by daily management clinical rounds by speaking to the residents/family, any of their concerns or grievances were followed up immediately and reviewed the grievances during morning meeting and address any concerns. Assistant Administrator C stated it was important to report an allegation of abuse and neglect for safety and protection of the residents and try to prevent other incidents of abuse.During an interview on 05/14/26 at 3:00 p.m., the DON stated she was notified by the RN weekend supervisor the morning of the incident on 11/09/25. The DON stated she immediately notified the Abuse Coordinator, which was the Administrator right after the RN weekend supervisor notified her. During an interview on 05/14/26 at 3:40 p.m., the Administrator stated he was notified by the DON the morning of the incident. The Administrator stated he did not feel the incident was reportable at the time he was notified that morning, and then after later review with his corporate team, he determined it was reportable. The Administrator stated he was notified the resident was upset and yelling at Resident #2 and got close to his face but did not make any physical contact with him. The Administrator stated later he had spoken to the DON, and she felt the incident was a reportable event. The Administrator stated after speaking to the DON he contacted his corporate staff and all agreed that it should be reported to the state. The Administrator stated he notified Assistant Administrator C around 5:00 p.m. to tell her to initiate a reportable event. The Administrator stated according to facility policy abuse should be reported within two hours of notification. The Administrator stated this incident was considered verbal abuse. The Administrator stated he was not in a location that permitted him to report at that time, so he contacted Assistant Administrator C and asked her to report. The Administrator stated he monitored abuse by daily rounds and open conversations with residents/staff to ensure comfortability to report concerns to her. The Administrator stated it was important to report allegations of abuse for the safety of the residents to prevent further incidents. Record review of the facility policy for Abuse Prohibition Policy, revised 02/26/26 reflected.each resident has the right to be free from abuse. Investigation: (2) The Abuse Coordinator will report such allegations to the state agency in accordance with state law.within two hours of the allegation.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have evidence alleged violations were thoroughly investigated for 1 of 18 (Resident #1) residents reviewed for abuse and neglect. The facility did not provide evidence of immediate corrective actions implemented according to the Provider Investigation Report of a Resident to Resident verbal altercation that occurred on 11/21/25 to include evidence that staff were provided and received the in-service training on abuse and neglect and the facility failed to provide evidence that Resident # 1 was monitored for 1:1 supervision for 1 of 5 (11/23/25) days. This failure could place residents at risk for abuse or neglect in that that facility did not thoroughly investigate the alleged violations and take appropriate corrective action as a result of the investigation findings.Findings included: Record review of Resident #1's face sheet dated 05/13/26 revealed a [AGE] year old male admitted [DATE] and readmitted [DATE] with diagnoses that included cerebrovascular disease (a group of conditions that affect blood flow and blood vessels in the brain), Diabetes Type II (a chronic condition where the body does not use insulin properly or cannot make enough insulin), anxiety (sudden feelings of intense fear or worry that interferes with daily life), and Dysthymic (a chronic form of depression). Record review of Resident #1's quarterly MDS dated [DATE] revealed he had no communication deficits and a BIMS score of 14 which indicated intact cognition. The MDS revealed Resident #1 had upper and lower extremity range of motion impairment, required the use of a wheelchair for mobility, supervision with eating, bed mobility, and moderate assistance in upper and lower body dressing, bathing, toileting, and transfers. Record review of the Provider Investigation Report (PIR) #1052028 dated 11/26/25 identified a Resident-to-Resident verbal altercation between Resident #1 and Resident #3 with immediate actions taken that included placing Resident #1 (aggressor) on 1:1 supervision. Record review of the 1:1 supervision and monitoring sheets revealed Resident #1 was placed 1:1 and monitored every hour on 11/21/25, 11/22/25, 11/24/25, and 11/25/25. The facility failed to provide evidence of 1:1 monitoring for 11/23/25. Record review of the PIR #1052028 dated 11/26/25 identified a Resident-to-Resident verbal altercation on 11/21/25 with immediate actions taken that included an all-staff in- service regarding Resident-to-Resident Abuse. The facility provided a copy of an in-service dated 11/24/25 and titled Resident-to-Resident Abuse but failed to provide evidence that staff received the in-service with an attendance roster or signature or attendance sheet. During an interview on 05/13/26 at 3:49 p.m., Assistant Administrator C stated that she was responsible for giving the in-services to the staff for any self-report allegations pertaining to abuse or neglect. Assistant Administrator C stated that some of the in-services are completed with a training application that is sent to the staff members' phone numbers. The Assistance Administrator C could not provide documentation of staff physical attendance at the Resident-to-Resident in-service or receipt of the in-service through the computer application program. During an interview on 05/13/26 at 10:33 a.m., CNA D stated that she had received multiple in-services on abuse and neglect but could not recall is she received an in-service on Resident-to-Resident Abuse on 11/24/26. CNA D stated if she observed a resident-to-resident altercation, she would separate residents who were arguing and ensure their safety, then tell the charge nurse. CNA D stated she was aware that Resident #1 was placed on 1:1 monitoring because of a verbal altercation, but stated that she was not assigned to complete the monitoring. During an interview on 05/13/26 at 5:08 p.m., the DON stated that the Assistant Administrator is responsible for ensuring the appropriate in-services are completed for staff when allegations of abuse or neglect are identified. The DON stated she does not check to ensure that all the staff have received the in-services. The DON stated that she believed the in-services were provided but did not have any documentation to provide. During an interview on 05/14/26 at 8:15 a.m., the Administrator stated that the Assistant Administrator C was responsible for the completion of the in-services. The Administrator stated that they were unable to locate the additional documentation to verify staff (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	received the in-service on 11/24/25 on Resident-to-Resident Abuse and the 1:1 tracking sheet for 11/23/25 that verified Resident #1 was monitored due to the Resident to Resident verbal altercation that occurred 11/21/25. During an interview on 05/14/26 at 8:50 a.m., the Activity Director stated that she had only been working at the facility for four months and was not familiar with the Resident-to-Resident verbal altercation that occurred on 11/21/25. Stated she did receive training on hire about abuse and how to intervene if residents were arguing. She stated she would separate the residents to keep them safe and then get the nurse for help. The Activity Director stated she would let the Administrator know because he was the Abuse Coordinator. During an interview on 05/14/26 at 9:48 a.m., LVN E stated that she had received multiple in-services on abuse and neglect but could not recall specifically if she received in-services on Resident-to-Resident Abuse on 11/24/26. LVN E stated that 1:1 monitoring is done every 15 minutes or every hour based on the recommendation from the DON or the Abuse Coordinator when the incident occurs. LVN E stated Resident #1 was placed on hourly monitoring because he was the aggressor in the Resident-to-Resident verbal altercation that took place on 11/21/25. LVN E was not able to identify what staff member was responsible for the 1:1 monitoring of Resident #1 for 11/23/25. During an interview on 05/14/26 at 1:21 p.m., the Social Worker stated that she had received multiple in-services on abuse and neglect but could not recall specifically if she received an in-service on Resident-to-Resident abuse on 11/24/26. The Social Worker stated she does not usually participate in the 1:1 monitoring as that task was done by the nursing department. The Social Worker stated that she was aware of the Resident-to-Resident verbal altercation that occurred on 11/21/25 and that Resident #1 was the identified aggressor and that is why he was placed on 1:1 monitoring. During an exit interview on 05/14/26 at 3:00 p.m., the DON stated that she believed the Resident-to-Resident Abuse in-service was completed but did not know where the attendance sheet could be. The DON stated that Resident #1 was the aggressor in the Resident-to-Resident verbal altercation that occurred on 11/21/25 which is why he was placed on 1:1 monitoring. The DON stated that she believed the nursing staff provided 1:1 for Resident #1 on 11/23/25 because the nursing MAR did indicate 1:1 was provided for each shift but acknowledged that it did not reflect the hourly monitoring and location of Resident #1. The DON stated that she expects the nursing staff to complete tracking for 1:1 on the hourly tracking sheets. The DON was unable to recall who was assigned to complete the 1:1 monitoring for 11/23/25. During an exit interview on 05/14/26 at 3:40 p.m., the Administrator stated he reviewed the documentation that was submitted in the Provider Investigation Report for this incident for accuracy and completeness. The Administrator stated that he had suspended the Assistant Administrator C after he learned during this survey that she was not keeping an accurate record of provided in-services. The Administrator stated that he expects nursing staff to complete 1:1 monitoring and tracking sheets if a resident is identified as requiring 1:1 monitoring based on the incident investigation and that he expected these documents to be included in the final investigation report. The Administrator stated he is ultimately responsible for ensuring the PIRs are accurate and complete and that failing to provide appropriate in-services for each allegation could result in harm or injury to the residents because the staff may not know what interventions to use. Record review of the facility policy titled Abuse Prohibition Policy, revised 02/26/26, revealed, in part, Investigation: 1. The facility will thoroughly investigate all alleged violations and take appropriate actions., 5. Investigations will be prompt, comprehensive and responsive to the situation., 6. All documentation of pertinent date to the investigation will be collected, maintained, and safeguarded in the Administrator/DON's office by the facility. Resident-to-Resident Incidents: 7. If the perpetrator is placed on location monitoring, staff will be instructed on the reason for monitoring and target behaviors being monitored.