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	07/31/2025

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 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. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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, if the events that caused the allegation involved abuse, for 1 of 8 residents (Resident #9) reviewed for abuse and neglect reporting. The facility failed to report to HHSC within 2 hours when Resident #9 alleged Resident #57 hit her on 06/17/2025. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: 1. Record review of Resident #9's face sheet dated 07/31/2025 indicated she was a [AGE] year-old female initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included rhabdomyolysis (muscle breaks down rapidly and releases breakdown into the blood), dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life), anxiety disorder. Record review of Resident #9's Quarterly MDS assessment dated [DATE] indicated she was usually understood by others, and she understood others. The MDS assessment indicated Resident #9 had a BIMS score of 13, which indicated she was cognitively intact. The MDS assessment indicated Resident #9 required partial/moderate assistance with personal hygiene and toileting hygiene and substantial/maximal assistance with showering/bathing. Record review of Resident #9's care plan with date initiated 07/08/2025 indicated she received physical aggression on 06/17/2025. Record review of Resident #9's Progress Notes dated 06/17/2025 indicated, The resident has informed the RN at this time she was hit on the arms by another resident. The resident states that she was hit by another individual while eating breakfast on her bilateral arms. The resident states she is not in pain and is fine. She also states she could not understand why the other resident hit her and couldn't understand her as she was speaking gibberish. Head to toe assessment conducted, ROM to extremities intact, no bruising noted at the time of assessment. Resident has denied pain. The victim and aggressor have been separated. The DON, ADMIN, RP, MD are aware and have been notified. Signed by MDS Coordinator B. 2. Record review of Resident #57's face sheet indicated she was an [AGE] year-old female initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life), recurrent major depressive disorder (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks), and anxiety disorder. Record review of Resident #57's Comprehensive MDS assessment dated [DATE] indicated she was sometimes understood by others, and she sometimes understood others. The MDS assessment indicated Resident #57 was unable to participate in the BIMS because she was rarely/never understood. The Staff Assessment for Mental Status indicated she had a short and long-term memory problem. The MDS assessment indicated Resident #57 had behavioral symptoms which could put others at significant risk of physical injury. Record review of Resident #57's care plan revised 07/07/2025 indicated she had a behavior problem related to increased agitation, episodes of hitting, and episodes of crying and asking for help. Resident #57's care plan indicated she had a potential to be physically aggressive related to dementia and poor impulse control with physical aggression initiated 06/17/2025. Record review of Resident #57's Progress Note dated 06/17/2025 indicated, The RN has been informed by another resident that this resident hit her on her arms. The resident is unable to recall the incident, these resident states, I don't know when asked about her description. The resident was removed away from the victim and placed on Q15 minute monitoring. The DON, ADMIN, RP, MD are aware and have been notified. Signed by MDS Coordinator B. During an interview on 07/30/2025 at 11:40 AM, MDS Coordinator B said Resident #9 reported to her another resident hit her on the arms while she was in the dining room. MDS Coordinator B said the resident who hit Resident #9 was Resident #57. MDS Coordinator B said when Resident #9 reported the incident to her she was still in the dining room, but the aggressor was not in the area so Resident #9 was safe. MDS Coordinator B said she assessed Resident #9, and she did not have any bruising or pain. MDS Coordinator B said she notified the DON, Administrator, RP, and doctor. MDS Coordinator B said she could not remember if it was witnessed or not. MDS Coordinator B said Resident #9 had reported it to her and she reported it to the above authorities. MDS Coordinator B said she reported the incident because it could be considered abuse. During an interview on 07/30/2025 at 11:51 AM, the Administrator said he was notified by MDS Coordinator B of the incident in the dining room between

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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 interview and record review the facility failed to ensure assessments accurately reflected the resident status for 1 of 28 residents (Resident #11) reviewed for MDS assessment accuracy. The facility failed to accurately document Resident #11's tobacco use. This failure could place residents at risk for not receiving care and services to meet their needs.Findings included: Record review of Resident #11's face sheet dated 07/31/2025 indicated he was a [AGE] year-old male initially admitted on [DATE] and re-admitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #11 was able to make himself understood and usually understood others. The MDS assessment indicated Resident #11 had a BIMS score of 12, which indicated his cognition was moderately impaired. The MDS assessment did not indicate Resident #11 used tobacco. Record review of Resident #11's care plan revised 06/30/2025 indicated Resident #11 was a smoker. Record review of Resident #11's progress note dated 06/10/2025 indicated Resident #11 was a current smoker. During an interview on 07/30/2025 at 11:40 AM, MDS Coordinator B said she completed Resident #11's Comprehensive MDS assessment with an ARD of 06/14/2025. MDS Coordinator B said Resident #11 should have been coded for the use of tobacco because he smoked. MDS Coordinator B said when she completed the MDS assessments she went through the smoking list and reviewed it. MDS Coordinator B said it was her mistake and she may have overlooked it. MDS Coordinator B said when an MDS was not coded accurately it was an error and could affect the billing, and she did not think it could affect the resident directly. During an interview on 07/31/2025 at 4:43 PM, the Administrator said he expected for the MDS assessments to be coded correctly, according to the policies. The Administrator said the MDS Coordinators were responsible for ensuring this happened. The Administrator said if the MDS was not coded according to the resident's plan the interventions in place would not be beneficial to the patient. Record review of the facility's policy titled, MDS Coding Policy, reviewed 06/02/2025, indicated, .affiliated facilities utilize the most up to date Resident Assessment Instrument (RAI) manual for determination of coding each section of the Resident Assessment, timely and accurately.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR) Level I assessment was completed for 1 of 4 residents (Resident #7) reviewed for PASRR Level I screenings. The facility failed to complete the PASRR level 1 screening for Resident #7 who was admitted on [DATE] and had a diagnosis of Schizophrenia on admission. This failure could place residents who had a mental illness at risk of not receiving a needed assessment PE (PASRR Evaluation), individualized care, or specialized services to meet their needs. Findings included: Record review of Resident #7's face sheet, dated 07/31/25, indicated he was an [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included schizophrenia (a chronic brain disorder characterized by symptoms like hallucinations, delusions, and disorganized thinking), anxiety (a feeling of unease, worry, or fear, often experienced as a normal reaction to stress), and depression (a common mental health condition characterized by persistent sadness and a loss of interest in activities, significantly impacting daily life). Record review of Resident #7's quarterly MDS assessment, dated 07/19/25, indicated he was severely cognitive impaired on decision making. He was able to make himself understood and he was able to understand others. He received an antipsychotic and an antianxiety medication routinely. Record review of Resident #7's electronic medical records did not indicate a PASRR level 1 screening was done, after he admitted on [DATE]. During an interview and observation on 07/31/25 at 10:33 a.m., the MDS Coordinator F said she had been the MDS Coordinator since November 2024. She said she was responsible to ensure a PL1 was completed on any resident when they admitted to the facility. She said Resident #7 was a previous resident but discharged December of 2024 and re-admitted [DATE]. She said since Resident #7 had been discharged for over 30 days then a new PL1 should have been completed. She said she did Resident #7's PL1 yesterday (07/30/25) after been questioned by the state surveyor, and realizing she had not done Resident #7's PL1. She said since Resident #7's PL1 was not completed then LIDDA was not alerted to do a PE. She said it was important for PL1's to be done to see if a resident would meet the criteria to receive services. During an interview on 07/31/25 at 11:43 a.m., the DON said the MDS Coordinator F was responsible to ensure the PL1 was filled when Resident #7 admitted to the facility. She said if Resident #7 admitted with a diagnosis of Schizophrenia, then a PL1 should have been done so a PE could have been done to determine if he would be able to receive services. During an interview on 07/31/2025 at 12:12 p.m., the Administrator said the MDS Coordinator was responsible to ensure the PL1 was done on admission. He said the risk was that the resident could have had PASRR services since they were admitted with the MI diagnosis. During an interview on 07/31/25 at 12:18 p.m., the Regional Compliance Nurse said they did not have a facility policy for PASRR and used the guidelines from the RAI manual. Record review of the RAI manual section A1500: Preadmission Screening and Resident Review (PASRR): All individuals who are admitted to a Medicaid certified nursing facility, regardless of the individual's payment source, must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), developmental disability (DD), or related conditions (please contact your local State Medicaid Agency for details regarding PASRR requirements and exemptions). Individuals who have or are suspected to have MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State. A resident with MI or ID/DD must have a Resident Review (RR) conducted when there a significant change in the resident's physical or mental condition. Therefore, when an significant change in status assessment (SCSA) is completed for a resident with MI or ID/DD, the nursing home is required to notify the State mental health authority, intellectual disability or developmental disability authority (depending on which operates in their State) in order to notify them of the resident's change in status. Section 1919(e)(7)(B)(iii) of the Social Security Act requires the notification or referral for a significant change.1 Each State Medicaid Agency might have specific processes and guidelines for referral, and which types of significant changes should be referred. Therefore, facilities should become acquainted with their own State requirements.Preadmission Screening and Resident Review:Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that Medicaid-certified nursing facilities:Evaluate all applicants for serious mental illness (SMI) and/or intellectual disability (ID), Offered all applicants the most appropriate

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to develop and implement a baseline care plan for each resident within 48 hours of admission that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 2 (Resident #123 and Resident #127) of 22 residents reviewed for baseline care plans. The facility failed to address Resident #123's vascular dementia diagnosis on her baseline care plan. The facility failed to ensure Resident #127's baseline care plan was completed within 48 hours of admission. These deficient practices could affect residents who are admitted to the facility with specialized needs and result in missed care.Record review of Resident #123’s face sheet dated 7/31/25 indicated she was an [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses diabetes mellitus (disease in which results in too much sugar in the blood stream), high blood pressure, cerebrovascular disease (group of conditions that impact the brain’s blood flow), normal pressure hydrocephalus (where excessive spinal fluid builds up in the ventricles), and history of falling. The face sheet did not indicate Resident #123 had a diagnosis of vascular dementia. Record review of Resident #123’s admission MDS dated [DATE] indicated she could understand others and could make herself understood. The MDS also indicated she had a BIMS score of 11 which meant she had moderately impaired cognition. The MDS also indicated she required substantial/maximal assistance from staff for toileting, bathing, moderate assistance with transfers and setup for eating but did not include the diagnosis for non-Alzheimer’s dementia in section I4800. Record review of Resident #123’s base line care plan dated 07/17/25 and unsigned by a nurse indicated she was a diabetic and alert. The baseline care plan did not indicate Resident #123 had vascular dementia or any cognitive loss. During an interview on 07/28/2025 at 3:27 PM Resident #123’s family member said she feels felt as though the staff does did not know that she has had dementia. During an interview on 07/31/2025 at 4:21 PM, ADON F said Resident #123’s baseline care plan should have been completed within 48 hours of admission date 07/17/25. She said vascular dementia was an important diagnosis to be included in the baseline care plan. ADON F said the failure of not ensuring the baseline care plans were complete and accurate placed a risk for Resident #123’s needs not being met. During an interview on 07/31/2025 at 5:02 PM the DON said she expected the baseline care plan to include the dementia and the cognition as well. She said the charge nurses were responsible and then the ADON should have reviewed and discussed in the morning meetings. During an interview on 07/31/2025 at 5:12 PM the Administrator said the charge nurses were responsible for completing the baseline care plans. He said the dementia diagnosis was important to be included in the baseline care plan. The Administrator said the failure of not completing the baseline care plan and including the dementia diagnosis placed a risk for nurses not being aware of what to treat Resident #123 for and could potentially cause harm to the resident. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #127’s face sheet dated 07/31/25, indicated a [AGE] year-old male who admitted to the facility on [DATE]. Resident #127’s diagnoses included heart failure (heart muscle does not pump blood as well as it should), peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and acute respiratory failure with hypoxia (lungs cannot adequately oxygenate the blood, leading to low blood oxygen levels). Record review of Resident #127’s EMR on 07/31/25 indicated the admission MDS assessment had not been completed. Record review of Resident #127’s baseline care plan indicated it was completed on 07/29/25 by LVN R. This indicated the baseline care plan was completed 2 days late. During an interview on 07/31/25 at 12:41 PM, ADON F said the baseline care plan was completed within 48 hours of admission and the admit nurse was responsible for completing it. The ADON said if the admit nurse was not able to complete the baseline care plan, then the oncoming nurse was responsible for completing it. ADON F said the baseline care plan gave the staff a baseline for the care needed to take care of the resident. The ADON said if the baseline care plan was not completed timely then they would not know if the resident’s needs were being met. During an interview on 07/31/25 at 12:44 PM LVN R said she did not complete Resident #127’s baseline care plan when he admitted on [DATE] because he admitted late to the facility and did not have time. She said the oncoming nurse should have completed it. LVN R said they usually relayed what was not completed on the admission checklist to the oncoming nurse during report. LVN R said the nurses were responsible to complete the baseline care plans within 24 hours. She said by not completing the baseline care plan timely, the staff would not know how to care for the resident. During an interview on 07/31/25 at 12:25 PM, the DON said the baseline care plans were completed within 24 hours by the admission nurse. The DON said the ADONs were responsible for checking the resident’s chart the next day to ensure all assessments were completed. The DON said failure to complete the baseline care plans timely placed the resident at risk for the staff not knowing the care the resident required. During an interview on 07/31/25 at 12:51 PM, the Administrator said the baseline care plans were to be completed within 48 hours of admission because they allowed the staff to be aware of the specific needs of the resident. He said the IDT was responsible for ensuring the baseline care plans were completed timely. He said by not completing the baseline care plan the staff would not be able to meet the resident’s needs. Record review of the facility policy “Care Plans-Baseline revised October 2023 indicated: Policy Statement A baseline plan of care to meet the resident’s immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. Policy Interpretation and Implementation (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident…”

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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 interviews and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 2 of 28 residents (Residents #5 and Resident #112) reviewed for care plans. 1. The facility failed to ensure Resident #5's care plan included her fall on 07/19/25 and the use of the non-strip strips and cervical collar (a collar used around the neck to support the neck and spinal cord after an injury) that should always remain in place. 2.The facility failed to update Resident #112's care plans for nectar thick liquids on 06/27/25. These failures could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs.1.Record review of Resident #5’s face sheet dated 07/31/25 indicated she was a [AGE] year-old female who re-admitted to the facility on [DATE] with the diagnoses Multiple fractures of Ribs, lack of coordination, high blood pressure, diabetes mellitus (disease in which too much sugar is in the blood stream), and polyneuropathy (general term for peripheral nervous system disorders that impact nerve function in multiple areas of the body). Record review of Resident #5’s admission MDS dated [DATE] indicated she was able to understand others and able to make herself understood. The MDS also indicated she had a BIMS score of 15 which meant she was cognitively intact. The MDS also indicated she had falls in the last month, she had falls in the last six months that resulted in fractures, and she had a fall since admission to the facility. Record review of Resident #5’s care plan revised 05/29/25 indicated she had ADL self-care deficit and required moderate assistance with toileting, transfers, bed mobility, and dressing, and she was independent with eating. The care plan also indicated she had limited mobility, and she was a high risk for falls with interventions to ensure resident was aware of the need to call for assistance, assist with toileting, and assist with transfers. The care plan did not indicate Resident #5 had a fall on 07/19/25 and always required a cervical collar. Record review of Resident #5’s order summary report dated 07/31/25 did not indicate she had an order for the cervical collar. Record review of Resident #5’s hospital encounter dated 07/25/25 indicated she was to always wear the cervical collar when up and out of bed. During an observation on 07/28/2025 at 11:32 AM Resident #5 was sitting in her room in her wheelchair with a cervical collar on her neck. During an interview on 07/31/2025 at 4:55 PM MDS Coordinator Q said she was responsible for completing and updating the care plans for Resident #5. She said she should have care planned the fall on 07/19/2025 in Resident #5’s bathroom and interventions of non-slip strips should have been added but failed to mention the cervical collar. MDS Coordinator Q said they usually had morning meetings daily and they updated the care plans each day, but she did not know how she missed updating Resident #5’s care plan. She said the failure placed a risk of not ensuring the staff were providing the proper care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/31/2025 at 5:04 PM the DON said she expected the cervical collar and the most recent fall on 07/19/25 with interventions to be included in the care plan. The DON said MDS Coordinator Q was responsible for ensuring Resident #5’s care plan was updated. She said the failure placed the risk of the staff not knowing how to care for Resident #5 and could possibly cause further injuries. During an interview on 07/31/2025 at 5:10 PM the Administrator said the fall on 07/19/25 and the cervical collar use should have been in the care plan along with the intervention for the care. He said MDS Coordinator Q was responsible for updating the care plans for Resident #5. The Administrator said the management staff discussed falls and admissions daily in the meetings. He said the failure placed a risk of harm to the Resident #5 or a repeat of the same incident/fall. 2.Record review of Resident #112’s face sheet, dated 07/31/25 indicated he was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included, dysphagia (medical term for difficulty swallowing solids, liquids, or both), dementia (the loss of cognitive functioning — thinking, remembering, and reasoning), hypertension (high blood pressure), and gastroesophageal reflux disease also known as GERD (a digestive disorder where stomach acid frequently flows back into the esophagus, irritating the lining. Record review of Resident 112’s annual MDS assessment, dated 07/10/25, indicated Resident #112 was understood and understood by others. Resident #112 was moderately impaired in decision making. The MDS indicated Resident #112 required assistance with her ADLs such as eating and personal hygiene. The MDS indicated she was altered mechanical diet. Record review of Resident 112’s Physician order dated 06/27/25 revealed Resident #112 had a Regular diet Mechanical Soft texture, Nectar Thickened consistency. Record review of Resident #112’s comprehensive care plan, dated 03/07/25, revealed Resident #112 had a Regular diet, mechanical soft texture, with thin consistency. The intervention was for staff to provide and serve diet as ordered. During an observation and interview on 07/31/25 at 10:39 a.m., RN G looked in Resident #112’s medical records and said she had an order for nectar thick liquid consistence. He said since she required nectar thick liquids it should have been care planed. During an interview on 07/31/25 at 11:07 a.m., the DON said the MDS Coordinator was responsible for the care plans. She said they talked about the resident’s changes during the morning stand-up meeting and the clinical meeting every Wednesday. She said she could not say why the MDS Coordinator F had not updated Resident #112’s care plans. The DON said the nectar thick liquids should have been on Resident #112’s care plan. She said the purpose of the care plans was to keep everyone informed of the resident's wishes and care. During an interview on 07/31/25 at 12:14 p.m., the Administrator said the MDS Coordinator was responsible for the care plans. He said care plans were done for the care the resident needed. He said interventions were put in place so that staff would know what care the resident required. He said department heads were responsible for ensuring the staff was following the care plan. (continued on next page)

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	676275	A. Building B. Wing	07/31/2025

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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy titled, “Comprehensive Person-Centered,” revised 01/23, indicated, “Policy: A comprehensive, person-centered care plan that includes measurable objective and timetable to meet the resident’s physical, psychosocial and functional needs is developed and implemented for each resident. #13 Assessments of residents are ongoing, and care plans are revised as information about the residents and the resident conditions change.”

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene for 1 of 28 residents (Resident #110) reviewed for ADLs. The facility failed to provide Resident #10's showers as scheduled for the month of July 2025. These failures could place residents at risk of not receiving needed services and care, decreased self-esteem, and a decreased quality of life. Findings included: Record review of Resident #110's face sheet dated 07/31/2025 indicated he was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs), atrial fibrillation (irregular, often rapid heart rate), and type 2 diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel). Record review of Resident #110's Comprehensive MDS assessment dated [DATE] indicated he was understood by others and understood others. The MDS assessment indicated Resident #110 had a BIMS score of 15, which indicated his cognition was intact. The MDS assessment indicated Resident #110 required partial/moderate assistance with showering/bathing. Record review of Resident #110's care plan revised 07/25/2025 indicated he had an ADL self-care performance deficit related to chronic obstructive pulmonary disease and to provide a sponge bath when a full bath or shower was not tolerated. Record review of Resident #110's shower sheets indicated he received showers on 07/18/2025, 07/23/2025, 07/25/2025, 07/28/2025, and 07/30/2025. There was no shower sheet for 07/21/2025. During an observation and interview on 07/28/2025 at 11:31 AM, Resident #110 said he had only received one bath since his admission, and it was one week ago. Resident #110 said he could not stand the smell of himself. Resident #110 said he did not know when his scheduled bath days were. Resident #110 said the only reason he had gotten the shower was because he reported it to the DON, and she made them give him a shower. Resident #110's hair appeared greasy and disheveled. During an interview on 07/31/2025 at 2:17 PM, CNA C said Resident #110 received his showers on Monday, Wednesday, and Friday on the 2 PM-10 PM shift. CNA C said Resident #110 did not refuse his showers. CNA C said she had not missed giving Resident #110 any showers, and she was not aware that he missed any showers. CNA C said it was important for the residents to receive their showers, so they did not have bad smells. During an interview on 07/31/2025 at 4:04 PM, LVN D said it had not been reported to her that the residents were not receiving showers. LVN D said she was not aware of Resident #110 missing any showers. LVN D said it had not been reported to her that Resident #110 refused any showers. LVN D said it was important for the residents to receive their showers for dignity. During an interview on 07/31/2025 at 4:08 PM, the DON said recently it had not been reported to her that residents were not receiving showers. The DON said she had not been told Resident #110 refused showers. The DON said Resident #110 had not reported to her he missed showers and that he may have told the ADONs. The DON said the ADONs were responsible for reviewing the shower sheets to ensure the residents received their showers. The DON said it was important for the residents to receive their showers because they did not want them to get skin issues or infections, and it was also for their dignity. During an interview on 07/31/2025 at 4:47 PM, the Administrator said showers should be completed according to the shower schedule. The Administrator said the CNAs were responsible for the showers, and the nurses should monitor the showers were completed every shift. The Administrator said if the residents did not receive their showers, it could affect their hygiene and for infection control. Record review of the facility's policy titled, Activities of Daily Living (ADL), Supporting, revised March 2018, indicated, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care) .

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 1 of 6 residents reviewed for quality of care. (Resident #123) The facility failed to begin neurological checks when Resident #123 had an unwitnessed fall on 07/30/25 at 3:10 PM. These failures could place residents at risk of a delay in treatments for the resident's conditions.Findings included: Record review of Resident #123's face sheet dated 7/31/25 indicated she was an [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses diabetes mellitus (disease in which results in too much sugar in the blood stream), high blood pressure, cerebrovascular disease(group of conditions that impact the brain's blood flow), normal pressure hydrocephalus (where excessive spinal fluid builds up in the ventricles), and history of falling. Record review of Resident #123's admission MDS dated [DATE] indicated she could understand others and could make herself understood. The MDS also indicated she had a BIMS score of 11 which meant she had moderately impaired cognition. The MDS also indicated she required substantial/maximal assistance from staff for toileting, bathing, moderate assistance with transfers and setup for eating. The MDS also indicated she received antipsychotic medications during the last 7 days or since admission to the facility. Record review of Resident #123's care plan dated 07/29/25 indicated she was at risk for falls r/t disorientation and increased risk of bleeding/bruising due to antiplatelet therapy with interventions to handle resident carefully when turning, positioning, or transferring, and sudden change in mental status, SOB, nose bleeds and report such findings to physician. Record review of Resident #123's fall note dated 07/30/25 at 3:10 PM indicated Resident #123 was found her on the floor beside her bed. During an observation and interview on 07/31/2025 at 09:50 AM Resident #123 was sitting in her wheelchair in the dining room with a family member. Resident #123 said she had a fall and she was ok but had anxiety. During an interview on 07/31/25 at 11:55 AM the DON said Resident #123 had an unwitnessed fall on 07/30/25 and should have had neurological checks check initiated at the time of the fall but the nurse failed to begin the neurological checks. She said she expected neurological checks to be completed on all unwitnessed falls or if a there was a fall with a resident hitting their head. The DON said she spoke with LVN E about the incident and LVN E said she did not feel like Resident #123 hit her head. The DON said the failure to complete neurological checks could place a risk for unknown injuries or change in condition. During an interview on 07/31/25 at 12:28 PM LVN E said she went into Resident #123's room after her fall and she just assumed that she did not hit her head because the way she was laying on the floor. LVN E said she examined Resident #123 and did not feel any bumps but she said the DON further instructed her on 07/31/25 to always begin neurological checks if a resident fall was unwitnessed. LVN E said the failure to start neurological checks after the fall could place Resident #123 at risk for internal bleeding or other issues if she hit her head. During an interview on 07/31/2025 at 4:30 PM The ADON F said the charge nurse at the time of the fall was responsible for starting neurological checks. She said the charge nurse should have assessed the resident, determined any injuries, and looked around and try to figure out how it happened. The ADON said the charge nurse should have notified the Medical Director, the DON, and Resident #123's family. She said neurological checks were expected to be completed for residents that had unwitnessed falls. The ADON F said not completing neurological checks could have caused the nurse to miss a change in condition. During an interview on 07/31/2025 at 5:15 PM the Administrator said he expected the charge nurse to follow the policy for falls and she should have begun neurological checks immediately after the fall when unwitnessed. He said the failure could have caused harm and the nurse could have missed a change in condition. Record review of the facility policy Policy for Resident and Visitor Accident Report revised 06/05/2025 indicated:Policy: The facility will conduct an investigation of all incidents involving residents of the facility.B. Resident Incidents/Accidents:1. If you witness an accident, you must immediately summon help.2. License nurse must: a. Examine the resident and obtain vital signs. B. If the resident hit his/her head or if the incident was unwitnessed initiate neurological checks.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remains as free of accident hazards as is possible for 1 of 3 residents (Residents #11) reviewed for accident hazards. The facility failed to ensure Resident #11 did not smoke a cigarette in the facility on 12/08/2024 and 07/11/2025. The facility failed to ensure Resident #11 was provided supervision while smoking on 07/29/2025. These failures could place residents at risk of accidents, injuries, or burns. Findings included: Record review of Resident #11's face sheet dated 07/31/2025 indicated he was a [AGE] year-old male initially admitted on [DATE] and re-admitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs), schizoaffective disorder bipolar type (mental health condition that is marked by a mix of symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania), and heart failure (chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen). Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #11 was able to make himself understood and usually understood others. The MDS assessment indicated Resident #11 had a BIMS score of 12, which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #11 required partial/moderate assistance with personal hygiene and bathing and set-up or clean-up assistance for toileting. The MDS assessment did not indicate Resident #11 used tobacco. Record review of Resident #11's care plan revised 07/15/2025 indicated on 07/11/2025 he was placed on a smoking schedule because he was found smoking in his room. Cigarettes and lighter were put in the nurse's cart. Resident # 11's care plan indicated to educate and encourage him to follow the facility designated smoking areas and policy, and he required supervision while smoking. Resident #11's care plan indicated he had an ADL self-care performance deficit related to impaired balance, and he was at risk for falls and injuries. Record review of Resident #11's Order Summary Report dated 07/31/2025 indicated Supervised smoking schedule. 7am 9am 11am 1pm 3pm 5pm 7pm 9pm every shift. Can go out supervised to smoke caught smoking in room with a start date of 07/12/2025. Record review of Resident #11's Smoking Safety Evaluations indicated: 06/11/2024- Resident #11 did not require supervision for smoking. Completed by the Clinical Services Coordinator. 12/08/2024- Resident #11 was confirmed a safe smoker/vaper. A note indicated resident was re-educated to smoke only outside of the building for safety reasons will continue to monitor. Completed by Nurse T. 01/29/2025- Resident #11 was confirmed a safe smoker/vaper. A note indicated resident appears to be a safe smoker at this time. However, resident has failed in the past to comply with smoking policies. Completed by the Social Worker. 04/28/2025- Resident #11 was confirmed to be a safe smoker/vaper. A note indicated no concerns being unsupervised. Completed by the Social Worker. 07/11/2025- Resident #11 was confirmed as not a safe smoker/vaper and must be supervised. Completed by the Social Worker. Record review of Resident #11's progress notes indicated: 12/08/2024 8:01 AM, Subjective : Patient is smoking in his room. Objective : Room smelled of cigarette smoke. Assessment : Patient caught smoking a cigarette in his room. DON notified. Plan : Education on the dangers of smoking indoors and near O2 explained to patient. Contraband (cigarettes and lighters) taken and placed in locked cart. Patient must ask nurse before going out to smoke. Nurse H8:23 AM, Patient caught smoking in his room. 11 cigarettes confiscated along with 9 lighters and locked in the med cart. LVN H 03/12/2025 6:21 AM, Skilled Nurse was informed by aid that Kitchen staff had seen resident on the floor outside the 300 hall exit door, SN made his way to the hall to see resident was in his wheelchair besides his bedroom door. Resident was asked what had happened and he stated that he went outside and began digging through the trash for cigarette butts so he could smoke, resident went further to claim that he had been outside since 1am which was demonstrably false since resident received his medication at 2:30am. Residents vital signs were taking [sic] and as follows: BP 101/57, Pulse 83, O2 97, Temp 96.9. Resident denied being in any pain r/t to fall. SN requested from resident a UA sample to check for UTI and resident refused, resident was also asked if it would be ok to ask the physician to put an order for a lab draw, resident once again refused. Resident has been and continues to be educated on the dangers of continually exiting the building at Night. The Resident was accompanied outside to smoke at the start of his daily smoking schedule. LVN K 04/27/2025 11:40 AM, Four lighters were confiscated from the resident's possession. Resident is still on supervised smoke breaks and is not allowed

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 1 of 5 residents reviewed for respiratory care. (Resident #42) The facility failed to administer Resident #42's oxygen as ordered on 07/28/25, 7/29/25, and 7/30/25. This failure could place residents who receive respiratory care at risk for developing respiratory complications.Findings included: Record review of Resident #42's face sheet dated 07/31/25, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (lung condition caused by damage to the airways that limit airflow), lung cancer, and acute respiratory failure (lung condition when the lungs cannot exchange oxygen and carbon dioxide properly). Record review of Resident #42's admission MDS assessment dated [DATE], indicated she was sometimes understood and sometimes understood others. Resident #42 had a BIMS score of 12, which indicated her cognition was moderately impaired. Resident #42 received oxygen therapy. Record review of Resident #42's comprehensive care plan dated 07/29/25, indicated Resident #42 had oxygen therapy related to respiratory illness. The care plan interventions indicated oxygen at 2 liters per minute via nasal cannula continuously. May titrate to 3-4 liters per minute to keep oxygen saturations greater than 90 percent. Record review of Resident #42's order summary report dated 07/29/25, indicated Resident #42 had an order for oxygen at 2 liters per minute via nasal cannula continuously. May titrate to 3-4 liters per minute to keep oxygen saturations greater than 90 percent every shift with an order date of 07/18/25. Record review of Resident #42's respiratory administration record dated 07/01/25-07/31/25, indicated she had an order for oxygen at 2 liters per minute via nasal cannula continuously and may titrate to 3-4 liters per minute to keep oxygen saturations greater than 90 percent. The administration record indicated Resident #42 had received oxygen every shift since Resident #42 admitted on [DATE]. During an observation on 07/28/25 at 11:22 AM, Resident #42 was in her bed and received oxygen at 5 liters per minute via nasal cannula. During an observation on 07/28/25 at 3:26 PM, Resident #42 was in her bed and received oxygen at 5 liters per minute via nasal cannula. Record review of Resident #42's progress note dated 07/28/25 at 11:05 PM and signed by RN S, indicated .Resident is up watching television at present.O2 @ 5 LPM via NC. During an observation on 07/29/25 at 09:47 AM, Resident #42 was in her bed and received oxygen at 5 liters per minute via nasal cannula. During an observation and interview on 07/29/25 at 4:48 PM, Resident #42 was in her bed and received oxygen at 5 liters per minute via nasal cannula. Resident #42's family member was at her bedside and said Resident #42's oxygen was supposed to be set at 5 liters because it was what Resident #42 had received when she was at the hospital. During an observation on 07/30/25 at 09:27 AM, Resident #42 was in her bed and received oxygen at 5 liters per minute via nasal cannula. During an observation and interview on 07/30/25 at 9:39 AM, LVN R went into Resident #42's room and observed the oxygen setting. LVN R said Resident #42's oxygen was set at 5 liters. LVN R reduced Resident #42's oxygen rate to 4. LVN R said the oxygen was set at the ordered rate of 4, but Resident #42's family member plays with it. LVN R said the nurse was responsible for checking the oxygen during their morning rounds. LVN R said failure to administer the oxygen at the ordered rate could cause Resident #42 to receive too much oxygen. During an interview on 07/30/25 at 2:35 PM, the Pulmonary Nurse Practitioner said when she saw Resident #42 at the facility her oxygen was constantly set at 5-6 liters and has had to bring it down to 4. She said she had educated the husband on not changing the oxygen setting. The Pulmonary Nurse Practitioner said Resident #42 had a 10-liter oxygen concentrator because she had end stage lung disease and if she had an emergency where she needed more oxygen, then she would have the correct concentrator. During an interview on 07/30/25 at 3:43 PM, Resident #42's family member said he did not touch the oxygen concentrator. He said the doctor at the hospital placed Resident #42's oxygen at 5 liters and he has not moved the settings. During an interview on 07/31/25 at 12:25 PM, the DON said she expected oxygen to be administered as ordered. The DON said the nurses were responsible for ensuring the oxygen was set at the ordered rate. She said failure to administer the oxygen at the ordered rate placed the resident at risk for desaturation or receiving too much oxygen. During an interview on 07/31/25 at 12:51 PM, the Administrator said he expected physician orders to be followed and the oxygen to be set at the ordered rate. He said the nurses were responsible to check during their shift that those orders were in place. Record review of the facility's policy Oxygen Administration and Oxygen Safety reviewed and revised on 07/23/25, indicated , The

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the drug regimen was free from unnecessary drugs for 1 of 5 residents reviewed for medications. (Resident #123) The facility failed to ensure Resident #123 had a diagnosis or adequate indication for quetiapine (Seroquel) (An antipsychotic medication used to treat certain mental/mood disorders such as schizophrenia, and bipolar disorder). The facility failed to ensure the proper consent form 3713 was completed prior to administering the medication quetiapine (Seroquel). This failure could place residents who received antipsychotic medications at risk of receiving unnecessary medication. Record review of Resident #123's face sheet dated 7/31/25 indicated she was an [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses diabetes mellitus (disease in which results in too much sugar in the blood stream), high blood pressure, cerebrovascular disease, normal pressure hydrocephalus, and history of falling. The face sheet did not indicate Resident #123 had a diagnosis of vascular dementia. Record review of Resident #123's admission MDS dated [DATE] indicated she could understand others and could make herself understood. The MDS also indicated she had a BIMS score of 11 which meant she had moderately impaired cognition. The MDS also indicated she required substantial/maximal assistance from staff for toileting, bathing, moderate assistance with transfers and setup for eating. The MDS also indicated she received antipsychotic medications during the last 7 days or since admission to the facility. Record review of Resident #123's base line care plan dated 07/17/25 and unsigned by a nurse indicated she was a diabetic and alert. The baseline care plan also indicated Resident #123 was taking psychotropic medications. The baseline care plan did not indicate Resident #123 had vascular dementia, any cognitive loss, nor did she have an approved diagnosis for the medication Seroquel. Record review of Resident #123's pharmacy recommendations dated 07/21/25 and provided to the facility on [DATE] indicated Resident #123 had an order for the antipsychotic medication quetiapine (Seroquel) and consents were required to be on the form 3713 provided by Texas Health and Human Services. The pharmacy recommendations also indicated Resident #123 was not confirmed to have an approved psychiatric diagnosis documented to support the use of the antipsychotic medication quetiapine (Seroquel). Record review of Resident #123's order summary report dated as of 07/29/25 indicated she had an order for:Quetiapine Fumarate oral tablet 25mg Give 1 tablet by mouth at bedtime for depression with a start date of 07/17/25 and no end date. Record review of Resident #123's EMR indicated she had the form 3713 for the antipsychotic medication quetiapine (seroquel) completed on 07/30/25 by the DON after surveyor intervention. During an interview on 07/31/25 at 11:35 AM, the DON said Resident #123 should not be taking quetiapine (Seroquel). She said she normally looked at resident's medications when they admit to the facility after the nursing team (DON and ADONs) reviewed new residents in the morning meeting, but she guessed they missed Resident #123's orders. The DON said Resident #123 should have an approved diagnosis to take quetiapine (Seroquel) and the consent form 3713 should have been completed by the admitting nurse or DON and ADON. The DON said the pharmacy consultant had been to the facility and should have made a recommendation as well but she had not reviewed the reports for Resident #123. She said the failure placed a risk for Resident #123 to have had adverse reactions to the medication. During an interview on 07/31/2025 at 4:34 PM, the facility Psychiatric Nurse Practitioner said she had seen Resident #123 on Tuesday 07/29/25 but she did not get to review her medications until Wednesday 07/30/25 and she discontinued the quetiapine (Seroquel) medication and began another medication Remeron (medication given for depression). She said Depression was not an approved diagnosis for any resident to take quetiapine (Seroquel). The Psychiatric Nurse Practitioner said the failure placed Resident #123 at risk for heart problems, irregular heartbeats, and a stroke. During an interview on 07/31/2025 at 5:13 PM, the Administrator said he was not familiar with the antipsychotic medications and consents but if needed he would have consulted the DON for those things. The Administrator said he expected the nurses to complete the necessary consents to give the medication. He said he expected the staff to follow the policy for antipsychotic medications and he assumed the risk was harm to resident. The Administrator said the risk was not following the policy and giving the patient medication without the proper consent. Record review of the facility policy Medication Management revised 10/01/19 indicated:Policy: In order to optimize the therapeutic benefit of medication therapy and minimize or prevent potential adverse consequences, facility staff, the attending physician/prescriber, and the consultant pharmacist perform ongoing monitoring for appropriate, effective, and safe medication use D. The resident's

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	676275	A. Building B. Wing	07/31/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 1 of 6 residents (Resident #60) and 1 of 3 medication carts (300-Hall nurse medication cart) reviewed for drugs and biologicals. 1. The facility failed to ensure Resident #60's medication labels for her amlodipine, carbidopa-levodopa, clopidogrel, and hydralazine matched her physician order. 2. The facility failed to ensure LVN D secured the 300-Hall nurse medication cart when it was not in use and unattended on 07/29/2025. These failures could place residents at risk of not receiving drugs and biologicals as needed, medication errors, medication misuse, and drug diversion.Findings included: 1. Record review of Resident #60's face sheet dated 07/31/2025 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included essential (primary) hypertension (high blood pressure), dysphagia oropharyngeal phase (disorder or impairment in swallowing), and acute on chronic combined systolic and diastolic congestive heart failure (disorder in which the heart's ability to contract and relax is impaired). Record review of Resident #60's Comprehensive MDS assessment dated [DATE] indicated she was rarely/never understood, and she rarely/never understood others. The MDS assessment indicated Resident #60 was not able to be interviewed for the BIMS because she was rarely/never understood. The Staff Assessment for Mental Status indicated Resident #60 had a long-term and short-term memory problem. Record review of Resident #60's Order Summary Report dated 07/31/2025 indicated: NPO diet with a start date of 06/10/2025. Amlodipine 10 mg give 1 tablet via g-tube one time a day with a start date of 06/11/2025. Carbidopa-Levodopa 25-100 mg give 1 tablet via G-Tube three times a day with a start date of 07/29/2025. Clopidogrel 75 mg give 1 tablet via G-Tube one time a day with a start date of 07/30/2025. Hydralazine 100 mg give 1 tablet via G-tube three times a day with a start date of 07/29/2025. During an observation of medication administration and an interview on 07/29/2025 starting at 9:12 AM, RN G prepared and administered Resident #60's medications via her g-tube. Resident #60's medication labels for the following indicated to administer the medications by mouth: amlodipine 10 mg give 1 tab by mouth once daily carbidopa and levodopa 25/100 give 1 tab by mouth three times daily clopidogrel 75 mg give 1 tab by mouth daily hydralazine 100 mg give 1 tablet by mouth three times a day.RN G said Resident #60 did not take anything by mouth. RN G said the order should match the medication label. RN G said he did not notice the medication label was not correct. RN G said the nurse was responsible for getting the medication label fixed. RN G said the nurses should be making sure the label was correct, and if it was not, they should call the pharmacy to let them know. RN G said the medication label not having the correct route could lead to a mistake. 2. During an observation and interview on 07/29/2025 at 3:04 PM, there was an unlocked, unattended medication cart towards the end of the 300 Hall. LVN D was observed coming down the hallway to the medication cart. LVN D said she was responsible for the 300-hall nurse medication cart, and she had stepped away because she was looking for one of her residents. During an interview on 07/29/2025 at 4:35 PM, LVN D said it was important for the medication cart to be locked when not in use and unattended so the residents could not get into the medication cart and get medications that did not belong to them. During an interview on 07/31/2025 at 4:10 PM, the DON said it was the nurse's responsibility to ensure the medication cart was locked when they walked away. The DON said they needed to ensure it was lock because they did not want any residents to wander over and take medications or somebody could take anything off the medication cart. The DON said the person administering medications should ensure the label was correct and the correct route was on the medication label. The DON said somebody missed it that the ADONs were supposed to be checking the medication carts every other day or at least weekly. The DON said if someone did not know Resident #60 could not receive medications by mouth, they could give it by mouth, and she could aspirate (could go into her lungs). During an interview on 07/31/2025 at 4:48 PM, the Administrator said the medication carts should be locked at all times when the nurse was not close by it. The Administrator said if the medication cart was left unlocked anyone could go by and have access to the medications or confused residents. The Administrator said dangerous things could happen. Record review of the facility's policy titled, Storage of Medications, reviewed 06/24/2025, indicated, 4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. 8. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. 9. Unlocked

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, interviews, and record review, the facility failed to provide food that was palatable, attractive, and at a safe and appetizing temperature for 1 of 3 meals (lunch meal) reviewed for palatability, attractiveness, and appetizing. The dietary staff failed to provide food that was palatable and appetizing temperature for the lunch meal on 7/29/25.The facility failed to follow puree recipe for carrots served on 7/29/25 (lunch meal). These failures could place residents at risk of decreased food intake, hunger, and unwanted weight loss. The findings included: 1. Record review of the menu indicated the lunch meal items on 7/29/25 included roasted turkey, carrots, scalloped potatoes, roll and cheesecake. During an interview on 7/28/25 at 11:03 a.m., Resident #67 stated she did not like the food, and the food was nasty tasting. During an interview on 07/28/2025 at 11:26 a.m., Resident #111 stated the food was not okay. During an interview on 7/28/25 at 11:56 a.m., Resident #55 stated the food was an issue around here; Resident #55 stated they do not know how to cook it; Resident #55 stated the food was bad. During observation and sample test tray of lunch meal on 7/29/25 at 12:45 p.m., the Dietary Manager stated the roasted turkey tasted good, carrots was hard and undercooked, scaled potatoes was warm and good, roll was not tasted, and cheesecake was good. The Surveyors stated roasted turkey tasted good, carrots were hard and needed to be hotter, scaled potatoes was good, roll was not tasted, and cheesecake was good. During an interview on 7/30/25 at 10:45 a.m., the Dietary Manager stated the Administrator oversaw him at the facility. The Dietary Manager stated he always tasted the foods every day at every meal. The Dietary Manager stated he did not taste the carrots served for lunch on 7/29/25. The Dietary Manager stated he handled food complaints by talking directly to the resident and seeing what the food complaint was then changing what the resident did not like. The Dietary Managers stated it was important to ensure the food was palatable, attractive and appetizing to the resident so the residents would eat the foods. The Dietary Manager stated people eat with their eyes first and if the food look good the residents would eat the foods. During an interview on 7/30/25 at 11:03 a.m., the Administrator stated he had been the Administrator since October of 2023. The Administrator stated he oversaw the dietary staff. The Administrator stated he ordered test trays from the kitchen once a week or as needed. The Administrator stated he was not aware of any recent food complaints from the residents. The Administrator stated he handled food complaints by talking to the residents and identifying the concerns then covering the concerns accordingly and lastly conducting in-services with the cook. The Administrator stated it was important to ensure the food was palatable, attractive and appetizing to the residents because it was part of what staff did and for the wellbeing and health for the residents. 2. Record review of the facility week 1 menu received on 7/29/25, indicated the lunch meal items included roasted turkey, carrots, scaled potatoes, roll and cheesecake. margarine, salt/pepper packets, choice of beverage, and water. Record review of the recipe for the carrot slice parslied for 10 or less residents on puree indicated to 2/3 cups of milk or appropriate liquid and 1 1/4 quarts of carrot sliced parslied. During observation of puree meal prep on 7/29/25 at 11:16 a.m., [NAME] A blended (1) cup of water and (3-4) Cups of carrot slice parslied. During an interview on 7/29/25 at 11:25 a.m , [NAME] A stated he had been a cook at the facility for 3 weeks. [NAME] A stated he completed in-services on following the recipe upon hire. [NAME] A stated the reason why he used water instead of following the recipe for the puree carrots because it slipped his mind. [NAME] A stated the facility had 8 residents on a puree diet. [NAME] A stated it was important to ensure he was following the recipe for nutritional value for the residents. During an interview on 7/29/25 at 2:51 p.m., the Dietician stated she had been the dietician since the 1st of February 2025. The Dietician stated she was not aware of the dietary staff was using water to puree meals, she said staff was not to use water to puree meals and she expected the dietary staff to follow the puree recipes. The Dietician stated she had limited oversight over the dietary staff, she said she oversaw meal checks and sanitation in the kitchen. The Dietician stated she had a short inspection and a long inspection once a month. The Dietician stated staff had not completed any in-services on following the recipes. The Dietician stated it was important to make sure the dietary staff was following the recipe for consistency of food products, consistency of puree foods, less of weight loss and wound healing. During an interview on 7/30/25 at 10:34 a.m., the Dietary Manager stated he had been the Dietary Manager since March of 2025, and he oversaw the dietary staff. The Dietary Manager stated he hired the cook and trained the cook to not to use water when pureeing foods. The Dietary Manager stated he expected staff to follow the recipe book. The Dietary Manager stated he completed an in-service with the cook on yesterday (7/29/25) for [NAME] A. The Dietary Manager stated it was important to ensure the dietary

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in (1 of 1) kitchen reviewed for dietary services, in that: 1) The Dietary staff failed to label and date all food items. 2) Dietary staff failed to effectively reseal, label and date frozen and refrigerated food items. These failures could place residents at risk for food contamination and foodborne illness. The findings included:During observations with Dietary Manager on 07/28/25 beginning at 10:11 a.m., the following observations were made in the kitchen Refrigerator (1 of 2):-(1) Gallon of premade orange juice was not label, had no expiration date and was prepared on 7/27/25. During observations with Dietary Manager on 07/28/25 beginning at 10:13 a.m., the following observations were made in the kitchen Refrigerator (2 of 2):-(1) sliced cheese bag unsealed, had an open date of 7/26/25 and no expiration date.-(1) cream cheese had a open date of 7/16/25 and no expiration date.-(1) Gallon of honey mustard had an open date of 6/12/25 and no expiration date. -(1) Gallon of honey mustard had a receive date of 11/20/24, open date of 4/16/25 and no expiration date. -(1) Gallon of salad dressing had a receive date of 11/6/24, open date of 7/26/25 and no expiration date.(1) container of spiced apples had an open date of 7/22/25 and no expiration date(1) container of sliced oranges had an open date of 7/24/25 and no expiration date. During observations with Dietary Manager on 07/28/25 beginning at 10:21 a.m., the following observations were made in the kitchen walk-in freezer (1 of 1):(1) hamburger Pattie not placed in a zip lock bag and bag was left unsealed.(1) Garlic biscuits had an open date of 5/27/25 and no expiration date. (1) bag of frozen turkey meat opened 7/11/25 had no expiration date. (1) bag of frozen chicken thighs had an open date of 7/25/25 and no expiration date. (1) box of dinner rolls bad was not sealed closed. (1) precooked hamburger patties bag was not sealed closed.(1) zip lock bag of pepperoni was not labeled or dated.(1) zip lock bag of fish Pattie was opened 2/11/25 and had no expiration date. During an interview on 7/30/25 at 10:50 a.m., the Dietary Manager stated he had been the Dietary Manager since March of 2025. The Dietary Manager stated the Administrator oversaw him at the facility. The Dietary Manager stated all food items found in the refrigerator and freezer were to be labeled, dated with receive date, open date and expiration date. The Dietary Manager stated staff completed in-services on labeling and dating on 7/29/25. The Dietary Manager stated staff last completed in-services on resealing refrigerated and frozen food items back in March of 2025. The Dietary Manager stated he conducted walk throughs in the kitchen every morning. The Dietary Manager stated the Administrator conducted walk throughs in the kitchen 3 times a week. The Dietary Manager stated if was important to ensure staff were labeling and dating refrigerator and frozen food items to ensure staff could tell how long they could use the foods for. During an interview on 7/30/25 at 11:05 a.m., the Administrator stated he had been the Administrator at the facility since October of 2023. The Administrator stated he oversaw the dietary staff at the facility. The Administrator stated all food items found in the refrigerator and freezer were to be labeled, dated with receive date, open date and expiration date. The Administrator stated he was not sure when the dietary staff last completed in-services on labeling and dating in the kitchen. The Administrator stated he was not sure if staff completed in-services on resealing refrigerated and frozen food items in the kitchen. The Administrator stated he conducted walk throughs in the kitchen 3 times a week. The Administrator stated it was important to ensure staff were labeling, dating and resealing refrigerated and frozen food items because he did not want to give the resident something that was expired. Record Review of food receiving a storage policy revised dated on 6/23/25 indicated (8) All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date).Record Review of refrigerator and freezer policy reviewed on 6/25/25 indicated Policy statement: This facility will ensure safe refrigerator and freezer maintenance, temperatures and sanitation, and will observe food expiration guidelines; (7) All food shall be appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. Use by dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and use by dates indicated once food is opened. (8) Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates. Supervisors should contact vendors or manufactures when expiration dates are in question or to decipher codes.

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Ridgecrest Healthcare and Rehabilitation Center	561 E Ridgecrest Rd Forney, TX 75126

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure the quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 of 4 residents (Resident #7) reviewed for hospice services. The facility failed to maintain Resident #7's hospice binder containing information related to hospice services provided for the resident such as the most recent plan of care, hospice election form, and physician recertification. These deficient practices could place residents who receive hospice services at risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care, and communication of resident needs. Findings included:Record review of Resident #7's face sheet, dated 07/31/25, indicated he was an [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included schizophrenia (a chronic brain disorder characterized by symptoms like hallucinations, delusions, and disorganized thinking), anxiety (a feeling of unease, worry, or fear, often experienced as a normal reaction to stress), and depression (a common mental health condition characterized by persistent sadness and a loss of interest in activities, significantly impacting daily life). Record review of Resident #7's quarterly MDS assessment, dated 07/19/25, indicated he was severely cognitive impaired on decision making. He was able to make himself understood and he was able to understand others. The MDS indicated Resident #7 was on hospice services. Record review of Resident #7's comprehensive care plan revised 04/21/25 indicated Resident #7 had a terminal prognosis and was on hospice services. The intervention was to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met, and for the nursing staff to provide maximum comfort for the resident. Record review of Resident #7's physician orders dated 04/09/25 indicated an order for {name} hospice. Record review of Resident #7's hospice binder revealed it did not have the Physician certification of the terminal illness, care plan, IDG (Interdisciplinary Group) meeting or Hospice election form. The last recertification was dated 02/20/25-05/20/25. During an observation and interview on 07/30/2025 at 2:38 p.m., ADON F look at Resident #7's hospice binder. She said the binder did not contain any orders, IDG meetings, plan of care or an updated recertification. She said the hospice company was supposed to bring the information needed in his binder. She said she was not sure how often the binder should be updated but would go ask and come back with an answer. ADON F said she was told by the DON that the binder should be updated every90 days and with any change of condition. She said she was responsible for ensuring the binder was updated. She said it was important for the hospice binder to be updated so staff was aware of his plan of care. During a phone interview on 07/30/2025 at 4:25 p.m., the hospice Office Manager said the binders at the facility should contain any supporting notes or documentation needed for Resident #7. She said they met every two weeks for the IDG meetings and said the documentation should be updated at least every 2 weeks after the IDG meetings. She said they had someone at the office who faxed the information to the facility but had been told the facility was throwing the information away or not updating the books. She said it was important to have the binders at the facility to help the facility know the care and services they were providing. During an interview on 07/31/2025 10:39 a.m., RN G said the hospice book should include the name of the hospice, diagnosis, sign in sheet and face sheet. He said management was responsible for ensuring the hospice binders were updated. He said any information the hospice company had for Resident #7 should be at the facility for effective communication because our care was combined. During an interview on 07/31/2025 at 12:04 p.m., the DON said ADON F was responsible for ensuring the hospice binders were updated. She said the books should be updated yearly and as changes were made. The DON said the failure to ensure those documents were at the facility was due to a lack of communication with the facility and the hospice company. She said all information done by hospice should be at the facility for communication and care coordination. During an interview on 07/31/2025 at 12:11 p.m., the Administrator said it was the ADON's responsibility to ensure all hospice documents were up to date. He said the books should be updated for effective communication between hospice and the facility for the care of the residents. Record review of the facility Hospice Agreement, dated 02/19/25, revealed, Hospice Patient medical records shall be in compliance with Federal State, and local laws and regulations. and with Medicare and Medicaid guidelines. Facility and Hospice shall prepare and maintain complete medical records for Hospice Patients receiving facility services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 6 residents (Resident #22 and Resident #53) and 2 of 2 staff (Treatment Nurse and Laundry Supervisor) reviewed for infection control. 1. The facility failed to ensure the Treatment Nurse changed her gloves when she removed Resident #22's dirty dressing on 07/29/25. 2. The facility failed to ensure the Treatment Nurse used proper PPE when providing wound care for Resident #53 on 07/30/25. 3. The facility failed to ensure the Laundry Supervisor was aware of Resident #53 being under contact isolation. These failures could place residents and staff at risk for cross-contamination and the spread of infection.Findings included: 1. Record review of Resident #22’s face sheet dated 07/31/25, indicated an [AGE] year-old female who readmitted to the facility 11/26/24. Resident #22 had diagnoses of dementia (memory loss) and muscle weakness. Record review of Resident #22’s quarterly MDS assessment dated [DATE], indicated she was able to be understood and understood others. Resident #22 had a BIMS score of 13, which indicated her cognition was intact. Resident #22 had one stage 3 pressure ulcer that was present upon admission/entry or reentry. Record review if Resident #22’s comprehensive care plan revised on 05/09/25, indicated she had a stage 3 pressure injury/ulcer to sacrum (triangular bone at the base of the spine). The care plan interventions included to administer treatments as ordered and monitor for effectiveness. Record review of Resident #22’s order summary report dated 07/31/25, indicated Resident #22 had an order to cleanse sacrum with wound cleanser/normal saline, apply collagen, skin prep to surrounding tissue or peri wound, secure with bordered gauze every day with an order date of 05/09/25. Record review of Resident #22’s treatment nurse MAR dated 07/01/25-07/31/25 indicated her wound care was provided daily. During an observation and interview on 07/29/25 at 10:24 AM, the Treatment Nurse entered Resident #22’s room disinfected the bedside table and washed her hands. The Treatment Nurse came back to her cart and obtained the wound care supplies. The Treatment Nurse and ADON F applied PPE and entered Resident #22’s room to perform wound care to Resident #22 sacrum. They both washed their hands and applied gloves. Resident #22 was turned to her right side. The Treatment Nurse removed Resident #22’s soiled dressing from her sacrum and disposed it in trash. The Treatment nurse then proceeded to cleanse Resident #22’s wound with normal saline and gauze. The Treatment Nurse failed to remove her dirty gloves before she cleaned Resident #22’s wound. The Treatment Nurse removed her gloves, washed her hands and proceeded to complete Resident #22’s wound care treatment. The Treatment Nurse and ADON F removed their PPE and washed their hands. The Treatment Nurse said she “could have sworn” she had washed her hands after she removed Resident #22’s dirty dressing. The Treatment Nurse said she was responsible for ensuring infection control was maintained when providing wound care and failure to do so placed the resident at risk for infection. (continued on next page)

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	07/31/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/31/25 at 12:25 PM, the DON said she expected wound care to be completed as ordered and infection control to be maintained. The DON said the Treatment Nurse should have changed her gloves when she removed Resident #22’s dirty dressing. She said failure to do so placed the resident at risk for infection. The DON said the Treatment Nurse was responsible for ensuring infection control was maintained when she performed wound care treatments. During an interview on 07/31/25 at 12:51 PM, the Administrator said he expected wound care to be performed as ordered and the facility’s infection control policy and procedure be followed. The Administrator said the nurses and the Treatment nurse were responsible to ensure infection control was maintained when wound care was performed. He said failure to do so placed the resident as risk for infection. The Administrator said the Treatment Nurse had told him that was not what had happened, regarding not changing her gloves after removal of the dirty dressing, the day the wound care was observed. 2.Record review of Resident #53’s face sheet dated 07/31/25 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses adult failure to thrive, elevated white blood cell count, malnutrition, and systemic inflammatory response syndrome. Record review of Resident #53’s admission MDS indicated she rarely made herself understood and could rarely understand others. The MDS also indicated she had short-term memory problems and long-term memory problems. Record review of Resident #53’s comprehensive care plan indicated she required enhanced barrier precautions for her feeding tube with interventions in place to provide signage on outside of room, enhanced barrier precautions during high-contact care including wound care. The care plan did not include contact isolation precautions. Record review of Resident #53’s order summary report indicated she had and order for: Isolation Precautions: Contact R/T (MRSA in wound exposure) every shift Initials acknowledge the following: Resident resided in room alone, and received all medications, participated in activities, received all meals, when applicable received all rehab services, and received all ADL care, in room the entire shift. every shift with a start date of 07/15/2025 and no end date. During an observation and interview on 07/30/25 at 2:04 PM the Laundry Supervisor was in the laundry and showed surveyor what the staff used when a resident was under contact isolation (which included an apron and gloves). She said the facility did not have any residents under contact isolation, but when the facility did have residents under contact isolation, their laundry was sent out in clear water-soluble bags and washed separately from other residents to prevent the spread of infection. (continued on next page)

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	676275	A. Building B. Wing	07/31/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 07/30/25 at 2:50 PM the Treatment Nurse went into Resident #53’s room, turned light on, spoke with Resident #53, moved bedside table, removed Resident #53 belongings on bedside table, and cleaned her bedside table to use for wound care supplies but failed to DON PPE prior to entering the room. The treatment nurse exited the room and used hand sanitizer for her hands and Donned PPE (gown and gloves) to perform the wound care for Resident #53. She performed wound care using proper technique. The Treatment Nurse then removed PPE to exit and only one biohazard box was in room for trash. Resident #53’s room did not have a box for soiled linen. The treatment nurse said she saw the contact isolation on Resident #53’s door and she should have placed the Gown and gloves on prior to entering the room to clean as well as provide care. She said there should also had been another isolation box in the room for soiled linen to be sent to the laundry. The Treatment Nurse said the failures placed increased risk for infection for residents and staff. During an interview on 07/31/2025 at 5:35 PM the DON said she expected the staff to [NAME] PPE prior to going into a resident’s room who is under contact isolation and the proper biohazard boxes to be in the room. She said the risk was increased infection for Resident #53 and spread of infection for the staff. She said the nursing staff were responsible for ensuring everyone is aware. During an interview on 07/31/2025 at 5:40 PM the Administrator said he expected nursing staff to be responsible for all infection control. He said all staff should follow the infection control policy. The Administrator said the failures placed a risk of infection and increased infection for Resident #53. Record review of the facility policy “Infection Control and Prevention revised 10/2022 indicated: Policy statement An infection and prevention program (IPCP)is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection…10) The Attending Physician and the interdisciplinary team will determine the treatment plan for the resident. a. If transmission-based precautions or other preventative measures are implemented to slow or stop the spread of infection, the Infection Preventionist will collect data to determine the effectiveness of such measures…11. Prevention of infection…7. Implementing appropriate isolation precautions when necessary…” Record review of the facility’s policy “The [Facility Corporate Name] Skin Integrity Prevention and Treatment Program” revised 07/2018, indicated “Wound Care. a. will follow the Non-Sterile Dressing Change Competency Protocol… c. Adheres to infection control best practices…”.