STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675109	A. Building B. Wing	03/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richardson Nursing and Rehabilitation	1111 Rockingham Dr Richardson, TX 75080

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure coordination of care with the Hospice agency, specific to each patient, for 1 (Resident #1) of 5 residents reviewed for hospice services. Resident #1 was sent to the hospital on [DATE] after her g-tube was dislodged and needed to be replaced. The facility failed to report this hospital transfer to the hospice agency. This failure could affect residents who received Hospice services by placing them at risk for services and treatments not being coordinated. Findings included: Record review of Resident #1's Annual MDS Assessment, dated 12/13/26, reflected an [AGE] year-old female, admitted [DATE] and readmitted [DATE]. Resident #1 did not have a BIMS score calculated, but was noted to have short and long-term memory problems along with severely impaired cognitive skills. Resident #1's active diagnoses included Alzheimer's Disease (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior), aphasia (a disorder that results from damage to areas of the brain responsible for language, affecting a person's ability to comprehend or formulate language), and stroke (a sudden interruption of blood flow to the brain, which can lead to brain damage and other serious complications). Record review of Resident #1's Order Summary Report, dated 03/14/26, reflected the following: Admit to [Hospice Company] DX: Alzheimer's Disease, Unspecified, Start of Care 6/30/2023 Record review of Resident #1's undated Care Plan reflected the following: [Resident #1] has chosen to admit to [Hospice Company] DX: Alzheimer's Disease, Unspecified, Start of Care 6/30/2023 [sic]. Record review of Resident #1's eINTERACT Transfer Form, dated 03/12/26 reflected her hospice company was not contacted about the transfer. Record review of Resident #1's Progress Notes reflected the following:LVN A wrote, Resident pulled her G-tube. MD notified with new order to send her to ER for g-tube replacement. Called [Ambulance Company] and scheduled transportation with ETA of 1 Hour [sic]. On 03/12/26 at 11:21 PM.LVN B wrote, Resdt [sic] transported to [Hospital Name] for G/Tube [sic] replacement via [Ambulance Company] EMS, stable, denies pain at this time, V/S 97.6, 78, 18, 98/64. Report called in and given to hosp [sic] ER via [phone number]. Family- [Resident #1's RP] notified via [phone number]. On 03/13/25 at 1:15 AM. During an observation on 03/14/26 at 12:45 PM, Resident #1 was in the hospital, lying in bed, and not able to respond to the surveyor's questions due to her condition as she was only able to look at the surveyor but was not able to verbally communicate or physically respond to the questions the surveyor was asking. During a telephone interview on 03/14/26 at 10:25 AM, Resident #1's Family Member revealed she was sent to the hospital the other night (she was unsure of the date) because she pulled out her g-tube. During an attempted telephone interview on 03/14/26 at 11:05 a.m., LVN B did not answer or call back prior to exit. A message was left with contact information and a request for a return call was made. During a telephone interview on 03/14/26 at 12:06 PM, a Hospice Representative revealed she spoke with Resident #1's RN Case Manager and said the hospice company was not informed of Resident #1's transfer to the hospital after her g-tube was pulled out. The Hospice Representative said she expected the facility to communicate with them when Resident #1 went to the hospital but they did not. During an interview on 03/14/26 at 2:37 PM, the DON (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed all nurses knew when a resident was on hospice and had a change in condition or was sent to the hospital, their hospice agency was supposed to be notified. The DON said the purpose of that was because they were part of the IDT team, provided care for residents, and needed to know what was going on with them. The DON said the nurse on duty would have been responsible for communicating those changes with the hospice agency. The DON said she was not aware Resident #1's hospice agency did not know she had gone to the hospital and were not notified of the transfer. The DON said the nurse managers normally would go back and check that all necessary parties were notified of Resident #1's hospital transfer but that was not done. The DON said if a resident's hospice agency was not notified of changes regarding a resident's care, they might not be able to continue with their plan of care. During a telephone interview on 03/14/26 at 3:43 PM, LVN A revealed when he was doing the last round of his shift when he was told Resident #1 pulled her g-tube out on 03/12/26. LVN A said he assessed Resident #1 and called the doctor to get the order to send her to the ER. LVN A said he also called the ambulance service to come pick her up and he communicated with LVN B ,who worked the next shift, to call the hospice agency and let them know about Resident #1 being transferred to the hospital. LVN A said he assumed since he communicated with LVN B, she would notify hospice. Record review of the facility's policy, revised 06/10/25, titled, Coordination of Hospice Services reflected, 10. The facility will immediately contact and communicate with the hospice staff, attending physician/practitioner and the family resident representative regarding any significant changes in resident's status, clinical complications or emergent situations.