

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Richardson Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 Rockingham Drive 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 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 observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 7 residents (Resident #1) reviewed for care plans. The facility failed to update Resident #1's care plan related to her recent fall. These failures could place the residents at risk of not receiving the necessary care and services. Findings included: Record review of Resident #1's Face Sheet, dated 07/27/26, revealed a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with Dementia (A progressive loss of memory, reasoning and communication skills). Record review of Resident #1's Quarterly MDS Assessment, dated 06/30/26, revealed the resident had severe cognitive impairment with a BIMS score of 02. The quarterly MDS Assessment indicated that the resident had inattention and disorganized thinking. Record review of Resident #1's Comprehensive Care Plan, dated 12/17/25, revealed that the resident did not have a care plan for falls. Record review of the incident report dated 07/31/26 revealed Resident #1 had an unwitnessed fall on 07/28/26 at 9:40 a.m. Record review of Resident #1's fall risk evaluation late entry date 07/28/26 revealed that the resident has not had a fall in the past 3 months with a fall risk score of 6.0. Record review of Resident #1's progress note dated 07/28/26 revealed that Resident #1 repeatedly refused to remain seated despite staff encouragement. Redirection was attempted six times without success. Resident continued to ambulate in the hallways. Nursing will continue to monitor the resident closely, provide frequent redirection, and implement fall prevention interventions as appropriate. Record review of Resident #1's progress note dated 07/28/26 revealed Resident #1 was assessed following a fall. Resident #1 denied pain or discomfort during the assessment. A cast to the left arm and hand remains intact with no visible concerns noted. Resident #1 was ambulatory throughout the hallways with an unsteady gait observed. During an observation and interview on 07/30/2026 at 9:30 a.m., Resident #1 was observed ambulating in her room, Resident #1 was observed with cast to left arm, she stated she fell, unable to describe how it happened. She appeared clean and well-groomed and denied any pain. During an interview on 07/31/26 at 2:15 a.m., the DON stated that Resident #1 had never had a fall in the facility and had no history of falls. She stated that everyone who is admitted is assessed for falls and a care plan for fall intervention is put in place, but the resident did not have one. She stated that with the recent fall there should have been a care plan update to include a fall risk and interventions to prevent falls. She stated that it was unintentional oversight that the fall care plan was not initiated. She stated that she has put a care plan in place with interventions for falls. She stated that she or the MDS nurses update the care plans. She stated that the fall was unwitnessed and the resident came to (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her that she had fallen and she was sent to the hospital and X-ray reports showed a fracture to the left wrist, and she had a cast put on. She stated that in services have been completed on best practice on how to document falls and keep the resident care plans updated. During an interview on 07/31/26 at 3:09 p.m., LVN G stated that Resident #1 came to report a fall and demonstrated how she fell. She stated the fall was not witnessed. She stated that an assessment was completed and her wrist looked twisted, the Nurse practitioner was contacted, and an order was given to send her to the ER. She stated that the protocol is to notify the physician, DON and family, she stated she placed an ice pack on her wrist while she waited to be picked up by the paramedics. She stated that the care plan should have been updated for falls risk, she stated that the DON and RN's update the care plans. She stated that she notified the DON of the fall. She stated that she is not sure why the care plan was not updated. She stated that she has been doing her nursing protocol follow up since the resident came back from the hospital. She stated that if the residents' care plan is not updated it could result in another fall. She stated that if the resident falls it will result in injuries and unnecessary hospitalization. Record review of the facility's policy Comprehensive Care Plans 2025 revision revealed It is the policy of this facility to develop and implement a comprehensive person-centered care plan for eachresident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident'smedical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident'scomprehensive assessment and meet professional standards of quality. Record Review of the facility's policy Fall Risk Assessment 2025 revision revealed It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control, and provides supervision and assistive devices to each resident to prevent avoidable accidents.1. The risk assessment will be completed by the nurse or designee upon admission, quarterly, or when a significant change is identified.2. The risk assessment will contain the following components:a. Identify environmental hazards and individual risks, including the need for supervisionb. Evaluate and analyze hazards and risks3. An At Risk for Falls care plan will be completed for each resident to address each item identified on the risk assessment and will be updated accordingly.4. The At Risk for Falls care plan will include interventions, including adequate supervision, consistent with a resident's needs, goals, and current standards of practice in order to reduce the risk of an accident.5. Monitor the effectiveness of the care plan interventions, and modify the interventions as necessary, in accordance with current standards of practice.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure the residents environment remained free of accidents and hazards for all residents reviewed for hazards. The facility failed to ensure that a gas-powered lawn [NAME] containing active liquid fuel was not stored inside a vacant area in the 2400 hall currently designated as a temporary storage area within an active renovation zone. This failure placed residents, visitors and staff at risk of harm and injury in the event of anfire. Findings include: During an interview and observation on 07/30/26 at 1:15 p.m., with the Maintenance supervisor it was observed that a lawn [NAME] with half a tank of gas was stored in the 2400 hall that was under renovation. The maintenance supervisor stated that the lawn [NAME] was not supposed to be parked inside the building and should be outside next to the dumpster 25-30 feet from the building. He stated that the lawn [NAME] is normally stored outside but was not sure how it got into the building. He stated that it was a safety hazard to have the lawn [NAME] stored inside the building, he stated that it could leak gas or oil and become a fire risk to the whole facility. He stated that he is responsible for making sure the [NAME] is stored properly outside and not in the building. He stated that he makes daily rounds to make sure the whole building is safe and secure and checks all exits to make sure they are secure but had not done so today due to having an emergency to fix a call light in a resident's room. He stated that he would move it outside immediately. During an interview on 07/31/26 at 4:45 p.m., the administrator stated that the lawn [NAME] should not be stored in the building but next to the dumpster for safety. She stated that Maintenance worker H does the land scaping, she stated that he stated that he left the lawn [NAME] outside next to the dumpster the last time he cut the lawn. She stated that they make rounds to ensure hazards are stored properly. She stated that they do rounds weekly but will be rounding daily to check for any safety issues going forward. She stated it is a fire hazard for a lawn [NAME] with a tank full of gas to be stored in the building. Record review of the facility's policy 2012 edition K-923 Health Care Facilities Code Requirements Gas Equipment -Cylinder and Container Storage revealed: ^ 3,000 cubic feetStorage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.^ 300 but <3,000 cubic feetStorage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.^ 300 cubic feetIn a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of ^ 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING.Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.		