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	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richardson Nursing and Rehabilitation	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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the resident had a right to confidentiality of his or her personal and medical records for five of eighteen residents (Residents #3, #5, #61, #73, and #79) reviewed for privacy and confidentiality. 1. The facility failed to ensure MA G secured Residents #3, #61, #73, and #79's medical information before leaving her cart on 03/11/2026. 2. The facility failed to provide privacy during Resident #5's transfer via mechanical lift on 03/10/2026.These failures could place the residents at risk of not having their personal privacy maintained while treatment and care were provided, which could result in the residents feeling uncomfortable during treatment and having their personal and medical record exposed to unauthorized individuals.Findings included: 1. Record review of Resident #3's Face Sheet, dated 03/12/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hypertension (high blood pressure). Record review of Resident #61's Face Sheet, dated 03/12/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hypertension. Record review of Resident #73's Face Sheet, dated 03/12/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hypertension. Record review of Resident #79's Face Sheet, dated 03/12/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hypertension. During an observation on 03/11/2026 at 6:41 AM revealed a small notebook was left on top of the MA's cart parked in the hallway. It was observed that on one page of the notebook were Residents #79, #3, and #73's vital signs written respectively. The nurse's cart was unattended and was facing the hallway with several staff and residents passing by the cart. During an observation on 03/11/2026 at 6:43 AM revealed MA G came out of one the resident's room and went straight to the rack to get a blanket and went back to a resident's room. Residents #79, #3, and #73's vital signs were still exposed. During an observation on 03/11/2026 at 6:44 AM revealed MA G came out of the resident's room and started to assist a resident in a wheelchair to the dining area. Residents #79, #3, and #73's vital signs were still exposed. During an observation on 03/11/2026 at 6:54 AM revealed MA G went inside Resident #61's room to get the resident's vital signs. After getting the vital signs, MA G wrote it on the page of the notebook where Residents #79, #3, and #73's vital signs were written. After writing Resident #61's vital signs, MA G prepared Resident #61's medications, and went inside Resident #61's room to administer his medications. Residents #79, #3, #73, and #61's vital signs were left exposed on top of the cart. During an interview on 03/11/2026 at 7:30 AM, MA G said she would usually cover her notebook every time she would leave her cart. She said maybe she got busy and forgot to do so. She said she should have flipped her notebook or placed it under her laptop so that whatever medical information written on it would not be exposed to everyone to see. She said vital signs were medical information and should be secured to prevent any HIPAA violations. During an interview on 03/11/2026 at 7:36 AM, the Infection Nurse said the residents' vital signs should not be left exposed because they were confidential information and should only be available to individuals that had something to do with the residents' care, like the nurses, physicians, responsible party, and therapists. She said the staff could also input the vital signs as soon as they had them, so the staff (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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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would not need to write the vital signs down. She said she would start an in-service about confidentiality of records. 2. Review of Resident #5's Face Sheet, dated 03/10/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness. Review of Resident #5's Quarterly MDS Assessment (assessment used to determine functional capabilities and health needs), dated 01/06/2026, reflected the resident was cognitively intact (resident may need additional support and monitoring) with a BIMS (screening tool used to assess cognitive status) score of 15. The Quarterly MDS Assessment indicated the resident was dependent on staff transfer from bed-to-chair transfer. Review of Resident #5's Care Plan, dated 02/27/2026, reflected the resident required extensive assistance by two staff with mechanical lift (devices used to move a person from one position to another). The plan did not indicate that the resident preferred to be transferred from the hallway to her room. During an observation on 03/10/2026 at 2:37 PM revealed CNA D and CNA E were about to transfer Resident #5 from wheelchair to the resident's bed via mechanical lift. While in the hallway, both CNAs hooked the sling, that was underneath the resident, to the mechanical lift and started to raise the mechanical lift. After the resident was up in the air, in the hallway, the CNAs started to push the mechanical lift towards the room of the resident and lowered the resident to her bed. During an interview on 03/10/2026 at 2:49 PM, CNA E said he did not know that a resident could not be transferred from the hallway. He said, though the resident was fully clothed, everybody could see that she was dependent on the staff for transfer. During an interview on 03/10/2026 at 2: 51 PM, CNA D said the resident was transferred from the hallway because the room was small. She said it did not occur to her that it was a dignity issue. During an interview on 03/11/2026 at 6:22 AM, Resident #5 said nobody talked to her about being transferred inside the room. She said it made sense that transfer should be done inside the room because everybody saw that she was aided by a mechanical lift to be transferred, was hanging in the air, and that as if she was too heavy to be transferred without the help of the mechanical lift. She said she might be fully clothed but other individuals could see that she was heavy. She said staff only talked to her about the transfer on the afternoon of 03/10/2026, Tuesday, when somebody was asking why she was being transferred from the hallway. During an interview on 03/12/2026 at 6:59 AM, the ADON said transferring the resident in the hallway could be a dignity issue because everybody could see the mode the resident was being transferred as well as the resident's inability to do the transfer herself. She said they talked to Resident #5 last 03/10/2026, Tuesday afternoon and that was the only time she knew that the resident preferred to be transferred from the hallway. She said because nobody talked to her about the transfer then it was a dignity and privacy issue because everybody could see how she was being transferred. She said the issue should have been addressed when staff saw that the resident was seen being transferred from the hallway. The ADON said medical information of any resident was confidential and should not be left unattended. She said the incident could be a HIPAA violation because other residents and visitors might see the information, or even staff that had nothing to do with the care of the residents. She said the staff should have secured it somewhere before leaving the cart. She said the notebook could have been turned over, left under the laptop, left inside the cart, or the staff could bring it with them. She said the expectation was for the staff to secure all confidential information before leaving their cart. She said the DON already started an in-service about privacy and confidentiality of records. During an interview on 03/12/2026 at 7:28 AM, the DON said she talked to Resident #5 last 03/10/2026, Tuesday afternoon, regarding being transferred from the hallway. She said she saw before that the resident was being transferred from the hallway and should have asked the resident and the staff about it. She said residents should be given privacy when being transferred. The DON said the vital signs written in the notebook were confidential information and should be protected. She said leaving the information exposed and unattended could be a HIPAA violation because unauthorized individuals might see them. She said the health information of a resident could not be shared without the permission of the resident or the resident's responsible party. She said if the confidential information was exposed, (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	non-nursing staff, other residents, and visitors might be able to see it. She said all staff, including her, were expected to provide confidentiality of all the residents' personal and medical information. The DON stated she had already started an in-service about privacy and confidentiality of medical records.During an interview on 03/12/2026 at 9:25 AM, the Administrator said the expectation was for the staff to have secured the residents' medical information before leaving their carts. She said the DON already started an in-service about confidentiality of records, but she would still coordinate with the DON to closely monitor if the staff understood the in-service regarding confidentiality of medical records. Record review of the facility's policy, HIPAA Security Measures The Compliance Store, undated, reflected Policy: It is the facility's policy to implement reasonable and appropriate measures to protect and maintain the confidentiality, integrity, and availability of the resident's identifiable information. Record review of the facility's policy, Resident Rights The Compliance Store, revised June 15, 2025, reflected Policy: The facility will inform the resident both orally and in writing . of his or her rights . 7. Privacy and confidentiality . The resident has a right to personal privacy and confidentiality of his or her personal and medical records . Personal privacy includes . personal 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 11 of 20 Resident rooms (room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11), and two of the six carpeted floor halls (2100 and 2500) observed for cleanliness. The facility failed to exercise reasonable care for the protection of the resident's property from loss or theft for 1 of 7 (Resident #15) reviewed for misappropriation of property. The facility failed to ensure Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11 were thoroughly cleaned and sanitized.The facility failed to ensure the carpeted floor halls on 2100 and 2500 were thoroughly cleaned and sanitized.The facility failed to protect Resident #15's property (Stainless steel bedpan) from loss. These deficient practices could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life and could negatively impact Resident #15's quality-of-life and self-esteem.Findings included: An observation on 03/10/26 at 10:06 a.m., revealed the carpet on the 2100 hallway had dark stains all over it. One area of the hall had a 15-inch circular dark gray stain. An observation on 03/10/26 at 10:15 a.m., of room [ROOM NUMBER], reflected the room floor had built up dirt in the corners of the door frame and corners of the floor. The air conditioning unit had black dirt and dust all over the front of the unit and between the vents. The air conditioning unit cover was hanging off the unit. An observation on 03/10/26 at 10:16 a.m., revealed the carpet on the 2500 hallway had a large dark stain, approximately four feet long, near the middle of the resident hallway. An observation on 03/10/26 at 10:20 a.m., of room [ROOM NUMBER], reflected the air conditioning unit had black dirt and dust all over the front of the unit and between the vents. An observation on 03/10/26 at 10:25 a.m., of room [ROOM NUMBER], reflected the entryway of the room floor had a thick yellowish stain. The floor had built up dirt in the corners and light grayish stains near the resident bed and in front of the mini fridge. The bedside table had dust and light grayish stains all over the lower frame. An observation on 03/10/26 at 10:28 a.m., of room [ROOM NUMBER], reflected the air conditioning unit had black dirt and dust all over the front of the unit and between the vents. An observation on 03/10/26 at 10:33 a.m., of room [ROOM NUMBER], reflected the air conditioning unit had black dirt and dust all over the front of the unit and between the vents. Some of the vents on the air conditioning unit were broken. The bathroom floor under the toilet had a large white stain circling a drain hole. An observation on 03/10/26 at 10:38 a.m., of room [ROOM NUMBER], reflected the air conditioning unit had black dirt and dust all over the front of the unit and between the vents. The bathroom floor under the toilet had a large white stain and grayish stains. A whiteboard on a wall, above a chest of drawers, had brownish stains An observation on 03/10/26 at 10:41 a.m., of room [ROOM NUMBER], reflected the air conditioning unit had black dirt and dust all over the front of the unit and between the vents An observation on 03/10/26 at 10:45 a.m., of room [ROOM NUMBER], reflected the air conditioning unit had black dirt and dust all over the front of the unit and between the vents. The bathroom floor had dark substances all over the center portion of the floor, the corners of the floor, and around the toilet. The room floor had built up dirt and dark stains near the closet door and along the door entrance. An observation on 03/10/26 at 10:49 a.m., of room [ROOM NUMBER], reflected the air conditioning unit had black dirt and dust all over the front of the unit and between the vents. An observation on 03/10/26 at 10:51 a.m., of room [ROOM NUMBER], reflected the air conditioning unit had black dirt and dust all over the front of the unit and between the vents. Some of the vents on the air conditioning unit were broken. The air conditioning unit filter appeared broken and was partially hanging out of the unit.An observation on 03/10/26 at 11:04 a.m., of room [ROOM NUMBER], reflected the air conditioning unit had black dirt and dust all over the front of the unit and between the vents. The bathroom floor had dark substances all over the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	center portion of the floor, the corners of the floor, and around the toilet. The room floor had dark stains all over the floor.During an interview on 03/12/26 at 11:12 a.m., Housekeeping T stated she had been at the facility for 3 years. She stated she cleaned the 2100 and 2500 halls. She stated they were responsible for cleaning the entire resident room. She was shown photos of the concerns observed in Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11. She stated they were responsible for cleaning the areas mentioned and they must inform their supervisor of areas of the floor they were unable to clean. She stated not cleaning the areas mentioned could cause the spread of germs. During an interview on 03/12/26 at 11:27 a.m., Housekeeping S stated she had been at the facility almost a month. She stated her peers trained her to clean the resident rooms. She stated they were to clean the entire resident room. She stated she cleaned all halls and was not assigned to any particular hall. She was showed photos of the concerns observed in Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11. She stated if the areas were not properly cleaned, residents could get sick. During an interview on 03/12/26 at 11:43 a.m., the Housekeeping Supervisor was informed of the concerns observed in Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11, Hall 2100, and Hall 2500. He stated they scrubbed the floors, but the stains did not come out. He stated the floors were old. He stated he in-serviced the staff on cleaning the rooms last month. He stated he is unsure of the impact the cleanliness of the resident rooms would have on the residents and would need to speak with a nurse to see what kind of impact it would have on them. During an interview on 03/12/26 at 12:10 p.m., the Administrator was informed of the concerns observed in Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11, Hall 2100, and Hall 2500. She stated she expected the resident rooms to be thoroughly cleaned. She stated they completed rounds with leadership and one of the check offs was to check for cleanliness. She stated the housekeeping supervisor should be checking the rooms to ensure they were properly cleaned. She stated not cleaning the rooms thoroughly could have respiratory concerns for residents. Record review of Resident #15's face sheet revealed she was a [AGE] year-old originally admitted to the facility on [DATE] with diagnoses which included but not limited to Depression, Bipolar Disorder, Non-Pressure chronic ulcer of Abdomen, Morbid obesity.Record review of Resident #15's MDS dated [DATE] revealed that the resident had a BIMS score of 15 (means the person has intact cognitive function).Record review of care plan dated 01/08/26 stated Resident #15 needs Toileting assistance of 1 staff with bedpan.Observation and interview on 03/11/26 at 8:50 am. Resident #15 was in bed resting, and when asked she stated she was doing well. However, her stainless-steel bed pan was lost when she moved rooms on 03/05/26 and is still missing. She stated the facility staff is using a plastic one which does not hold her urine and spills on the bed and pinches her skin when she is on it.Interview with Social Worker on 03/11/26 at 9:00 am, she stated a stainless-steel bed pan has been ordered.Interview with Resident #15 on 03/11/26, at 10:55 am, she stated that she was informed a replacement stainless steel bed pan has been ordered.Interview with Administrator on 03/11/26 at 11:00 am, she stated that a replacement stainless steel bed pan has been ordered on 03/11/26.Interview with Administrator on 03/12/26 at 9:50 am, she stated that she was not sure of what happened to the bed pan; it may have been taken by visitors or other residents. She confirmed that a new bed pan like what Resident #15 had was ordered from Walmart on 03/11/26. She confirmed that facility staff were aware Resident #15 had a stainless-steel bed pan that she prefers to use. She stated that they keep an inventory of resident belongings during admission and while they are residing at the facility. She stated that the facility investigates if any resident belongings come up missing and document it on the grievance log.Interview with Social Worker on 03/12/26 at 10:10 am, she stated that the protocol to move is the nurses / staff inform her of the move and why and she informs the resident about the move and why. Housekeeping moves the resident and belongings, but she was not sure if inventory is done before and after the move. She stated that she was informed by Resident #15 about the missing bed pan last week, not sure of the date, and the Administrator was made aware of it. She stated that Resident #15 not having her (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	preferred bedpan could result in emotional distress since they have very little belongings and have no control over the little, they have left.Interview with Housekeeping Supervisor on 03/12/26 at 10:20 am. He stated the Protocol is he takes a picture of resident's belongings before and after moving rooms. He stated he tries his best to arrange the resident's belongings as they were in the previous room and to residents' preference. He usually reports missing Items to the nurses if medical and others to the administrator. He stated he found out about the missing bedpan from CNA D on 03/05/26 and told the nurse on duty about it. Record review of the facility Policy on Resident Personal Belongings, (undated) reflected: It is the policy of this facility to protect the resident's right to possess personal belongings, such as clothing and furnishings, for their use while in the facility. The facility will ensure that personal belongings and/or possessions are rightfully returned to the resident, or to the resident's representative, in the event of the resident's death or discharge from the facility. All resident possessions, regardless of their apparent value to others, will be treated with respect.All resident personal items will be inventoried at the time of admission by the social services designee, or another designated staff member and documentation shall be retained in the medical record. Additional possessions brought in during the duration of the individual's stay shall be added to the existing personal belongings inventory listing.The facility will exercise reasonable care for the protection of the resident's property from loss or Theft.Inventories of all items are to be reviewed and examined by Social Services designee and the resident's representative. Recipients of such personal items at the time of discharge or death shall signoff with their legal signature, acknowledging receipt of all personal belongings presented. Review of the facility's policy on Resident Environmental Quality (undated) revealed It is the policy of this facility to be designed, constructed, equipped, and maintained to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure assessments accurately reflected the resident's status for three of eight residents (Residents #2, #5, and Resident #19) reviewed for accuracy of assessments. 1. The facility failed to ensure Resident #2's Comprehensive MDS assessment dated [DATE] accurately reflected that the resident was admitted to hospice. 2. The facility failed to ensure Resident #5's Comprehensive MDS assessment dated [DATE] accurately reflected that the resident was on oxygen therapy. 3. The facility failed to ensure Resident #19's Comprehensive MDS assessment dated [DATE] accurately reflected that the resident was using an AVAPS. These failures could place the resident at risk for not receiving care and services to meet their needs, diminished function of health, and regression in their overall health.Findings included: 1. Record review of Resident #2's Face Sheet, dated 03/11/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills) with a late onset. Record review of Resident #2's Comprehensive MDS Assessment, dated 01/21/2026, reflected the resident had a severe impairment (resident required significant assistance and support in daily life) in cognition with a BIMS score of 05. The Comprehensive MDS Assessment did not indicate that the resident was receiving hospice care. Record review of Resident #2's Comprehensive Care Plan, dated 01/13/2026, reflected that the resident had chosen hospice services and one of the interventions was to work cooperatively with the hospice team. Record review of Resident #2's Physician Order, dated 09/25/2024, reflected . HOSPICE . DX ALZHEIMERS DISEASE WITH LATE ONSET. 2. Record review of Resident #5's Face Sheet, dated 03/10/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with chronic pulmonary edema (too much fluid in the lungs) and heart failure. Record review of Resident #5's Quarterly MDS Assessment, dated 01/06/2026, reflected that the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment did not indicate that the resident was on oxygen therapy. Record review of Resident #5's Quarterly Care Plan, dated 02/27/2026, reflected that the resident had heart failure and one of the interventions was to administer oxygen as ordered. The Care Plan indicated that the resident started using oxygen on 08/07/2024. Record review of Resident #5's Physician Order, dated 02/26/2026, reflected Oxygen at 2 liters per minute via Nasal Cannula. every shift for SOB During an observation on 03/10/2026 at 2:37 PM revealed Resident #5 was in her wheelchair in the hallway. It was observed that the resident was on oxygen via a nasal cannula connected to the oxygen tank at the back of her wheelchair. During an observation and interview on 03/11/2026 at 6:22 AM revealed Resident #5 was in her wheelchair at the reception area of the facility. It was observed that the resident was using oxygen. She said she had been using oxygen for years and would use it night and day. 3. Review of Resident #19's Face Sheet, dated 03/12/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with sleep apnea (a sleep disorder where breathing is interrupted repeatedly during sleep). Review of Resident #19's Comprehensive MDS Assessment, dated 02/02/2026, reflected the resident had moderate impairment (resident may need additional support and monitoring) in cognition with a BIMS score of 12. The Comprehensive MDS Assessment did not indicate that the resident was using a non-invasive mechanical ventilator. Review of Resident #19's Comprehensive Care Plan, dated 02/02/2025, reflected that the resident did not have a care plan for a non-invasive mechanical ventilator. Review of Resident #19's Physician Order, dated 01/26/2026, reflected AVAPs (non-invasive ventilation mode that automatically adjust the air moving in and out of the lungs) settings Max-35, min-15, Peep +10, Rate - 26, 430 ML, 2L O2. Record review of Resident #19's Pulmonary Notes, dated 01/21/2026, reflected . wearing her AVAPS mask upon provider arrival . denies complaints associated with AVAPS. During an observation on 03/10/2026 at 9:12 AM revealed Resident #19 was not inside her room. It was observed that the (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident had AVAPs at the bedside. During an interview on 03/10/2026 at 10:43 AM, CNA F stated Resident #19 had been using her AVAPs since she was admitted to the facility and would use it every night. During an interview on 03/11/2026 at 12:12 PM, the MDS Nurse said Resident #19's AVAPs was not coded in her MDS because there was no documentation about the AVAPs. During an interview on 03/11/2026 at 12:24 PM, LVN A said Resident #19 had been using an AVAP since she was admitted to the facility. She said she was the one taking it off every morning. She said the respiratory department even taught her how to use the AVAP. During an observation and interview on 03/11/2026 at 12:46 PM, the MDS Nurse checked Resident #19's Progress Notes from the resident's admission to present and saw that the resident was using her AVAPS. She said if the resident was using an AVAPS, which was in the form of a non-invasive mechanical ventilator, since admission, then it should have been coded in the resident's MDS. The MDS Nurse said, the same was applicable to the resident who was admitted to the hospice and the resident who was using some oxygen. She checked on Resident #2's MDS and saw that the resident was not coded for hospice. She then checked Resident #5's MDS and saw the resident was not coded for her oxygen use. She said it was an oversight on her part and said she would fix it. She said the MDS was a form of a clinical assessment to determine the needs of the residents. She said if the assessment was not accurate, then there could be a probability that the needs would not be met. She said she would also audit the MDS of the other residents. During an interview on 03/12/2026 at 6:59 AM, the ADON said she was not familiar with the MDS but if the MDS needed to reflect that residents were using oxygen and AVAPs, then it should be in the MDS. She said the same with the resident receiving Hospice care. During an interview on 03/12/2026 at 7:28 AM, the DON said she was not familiar with the MDS but would coordinate with the MDS nurse to audit the MDS of the residents to make sure what should be coded was reflected in the MDS. During an interview on 03/12/2026 at 9:25 AM, the Administrator said the MDS of the resident should have been triggered if the resident was in hospice or were using oxygen and AVAPs. She said she would coordinate with the DON and the MDS Nurse about the issue. Record review of the facility's policy Conducting an Accurate Resident Assessment The Compliance Store revised May 05, 2025, reflected Policy: The purpose of this policy is to ensure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment . Policy Explanation and Compliance Guidelines . 3. The appropriate, qualified health professional will correctly document the resident's medical, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional abilities, and psychosocial status.

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	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, and mental and psychosocial needs that were identified in the comprehensive assessment for a resident for four of twelve residents (Residents #14, #15, #19, and #29) reviewed for care plans. 1. The facility failed to ensure Resident #14 was care planned for oxygen therapy. 2. The facility failed to ensure Resident #15 was care planned for congestive heart failure. 3. The facility failed to ensure Resident #19 was care planned for her AVAPS. 4. The facility failed to ensure Resident #29's care plan reflected an intervention for her bed to be in the lowest position for fall prevention and a plan of care for Enteral feeding. These failures could place the residents at risk of not receiving the necessary care and services. Findings included: 1. Record review of Resident #14's Face Sheet, dated 03/10/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with weakness. Record review of Resident #14's Comprehensive MDS Assessment, dated 01/29/2026, reflected that the resident had a severe impairment in cognition with a BIMS score of 06. The Comprehensive MDS Assessment indicated that the resident had muscle weakness. Record review of Resident #14's Comprehensive Care Plan, dated 02/09/2026, reflected that the resident did not have a care plan for oxygen therapy. Record review of Resident #14's Physician Order, dated 02/26/2026, reflected Oxygen at 2 liters per minute via Nasal Cannula or Mask. every shift for SOB. Record review of Resident #14's Progress Notes, dated 12/02/2025, reflected Monitor . Oxygen therapy protocol. Record review of Resident #14's Progress Notes, dated 12/21/2025, reflected Monitor . Oxygen Therapy. Record review of Resident #14's Progress Notes, dated 12/25/2025, reflected Monitor . Oxygen Therapy. Record review of Resident #14's Progress Notes, dated 01/24/2026, reflected Patient on O2@2-3L/m. Record review of Resident #14's Progress Notes, dated 02/11/2026, reflected on 3 liter of oxygen via N/C. Record review of Resident #14's Progress Notes, dated 10/26/2025, reflected Resident is on continuous oxygen therapy at 2 L. During an observation and interview on 03/10/2026 at 9:21 AM revealed Resident #14 was in her bed, awake. It was observed that the resident was using oxygen. When asked how long she had been using oxygen, the resident did not reply. During an interview on 03/10/2026 at 9:28 AM, CNA F said Resident #14 was using oxygen since she was admitted to the facility. During an observation and interview on 03/11/2026 at 1:07 PM, LVN C said the nurses were responsible in making the acute care plan. He said if Resident #14 came back from the hospital using the oxygen, then it should have been care planned by the admitting nurse. He said, but if the resident had been using oxygen since last year, then it should have been care planned since last year. He said he would check the resident's care plan and would make one for the resident's oxygen. 2. Record review of Resident #15's Face Sheet, dated 03/10/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with congestive heart failure (condition in which the heart cannot pump blood well enough to meet the body's needs). Record review of Resident #15's Quarterly MDS Assessment, dated 12/31/2025, reflected that the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated the resident had congestive heart failure. Record review of Resident #15's Comprehensive Care Plan, dated 01/11/2026, reflected that the resident was not care planned for congestive heart failure. Record review of Resident #15's Physician's Order, dated 12/29/2025, reflected Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 1 vial inhale orally three times a day for SOB/Congestion. During an observation and interview on 03/10/2026 at 9:10 AM revealed Resident #15 was in her bed, awake. It was observed that a nebulizer machine was on top of the resident's side table. The resident said she had breathing (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	treatments to help with her congestion. 3. Review of Resident #19's Face Sheet, dated 03/12/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with sleep apnea (a sleep disorder where breathing is interrupted repeatedly during sleep). Review of Resident #19's Comprehensive MDS Assessment, dated 02/02/2026, reflected the resident had moderate impairment (resident may need additional support and monitoring) in cognition with a BIMS score of 12. The Comprehensive MDS Assessment did not indicate that the resident was using a non-invasive mechanical ventilator. Review of Resident #19's Comprehensive Care Plan, dated 02/02/2026, reflected that the resident did not have a care plan for a non-invasive mechanical ventilator. Review of Resident #19's Physician Order, dated 01/26/2026, reflected AVAPS settings Max-35, min-15, Peep +10, Rate - 26, 430 ML, 2L O2. Record review of Resident #19's Pulmonary Notes, dated 01/21/2026, reflected . wearing her AVAPS mask upon provider arrival . denies complaints associated with AVAPS. During an observation on 03/10/2026 at 9:12 AM revealed Resident #19 was not inside her room. It was observed that the resident had AVAPs at the bedside. During an interview on 03/10/2026 at 10:43 AM, CNA F stated Resident #19 had been using her AVAPs since she was admitted to the facility and would use it every night. During an interview on 03/11/2026 at 12:12 PM, the MDS Nurse said Resident #19's AVAPs did not have a care plan because there was no documentation about the AVAPs. During an interview on 03/11/2026 at 12:24 PM, LVN A said Resident #19 had been using an AVAPs since she was admitted to the facility. She said she was the one taking it off every morning. She said the respiratory department even taught her how to use the AVAPs. During an observation and interview on 03/11/2026 at 12:46 PM, the MDS Nurse checked Resident #19's Progress Notes from the resident's admission to present and saw that the resident was using her AVAPs. She said if the resident was using an AVAPs, which was a form of a non-invasive mechanical ventilator, since admission, then there should be a care plan for the AVAPs. She then checked Resident #14's care plan and saw the resident did not have a care plan for her oxygen. She said if the resident was using oxygen when the resident was re-admitted to the facility, then there should be an acute care plan done for the resident. She said the nurses were responsible for the acute care plan. She said if a resident had a congestive heart failure, there should be a care plan for congestive heart failure. She said she would check Resident #15's care plan and would make a care plan for congestive heart failure. She said care plans should be in place, so the staff would know the interventions and goals for the resident and would be in sync in terms of the care to be provided. She said it was an oversight and she would fix it. During an interview on 03/12/2026 at 6:59 AM, the ADON said the care plan should be in place to protect the residents and the facility. She said the care plan reflected the needs of the residents that needed to be addressed. She said the care plan served as the facility's agreement with the resident in terms of the care and services that the facility would be providing. She said she would coordinate with the DON and the MDS nurse to fix the care plan and audit the care plans of the other residents. During an interview on 03/12/2026 at 7:28 AM, the DON said care plans were extensions of the care given to the residents. She said the care plans were to reassure that the residents were being taken care of. She said care plans should be in place and should reflect realistic goals and interventions and assess as well if the expectations were being met. She said the care plan should also be done if the resident had a fall, came back with an order for antibiotics, or was declining. She said if the resident was using oxygen, then there should be a care plan for oxygen. She said if the resident was using an AVAPs or had a congestive heart failure, then there should be care plan for both. She said she would coordinate with the MDS Nurse regarding the issue. During an interview on 03/12/2026 at 9:25 AM, the Administrator said the expectation was that all the residents were care planned appropriate to their needs. She said the care plans should indicate the care and services being provided. She said care plans should be in place so that the individuals providing care for the resident would be in sync. She said she would coordinate with the MDS nurse and the DON regarding the issues. 4. Record review of Resident #29's Face Sheet, dated 03/11/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #29 had (continued on next page)

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	675109	A. Building B. Wing	03/12/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnoses of lack of coordination and malnutrition.Record review of Resident #29's Quarterly MDS Assessment, dated 01/08/26, reflected the resident's BIMS indicated an intact cognitive response. The Quarterly MDS Assessment reflected the resident had active diagnoses of lack of coordination and malnutrition.Record review of Resident #29's Physician orders, dated 03/11/26, reflected Enteral Feeding for evening meals.Record review of Resident #29's Comprehensive Care Plan, dated 03/10/26, reflected no plan of care for the resident receiving Enteral feeding and Resident #29's plan of care for fall prevention did not include an intervention for the resident's bed to be in the lowest position.During an interview and observation on 03/10/26 at 2:15 p.m. LVN C observed Resident #29's bed in a low position. He stated he was unsure why the resident's bed was low. Resident #29 stated her bed was low because she had fallen out of bed about a year ago and had broken her knee cap. She stated she wanted her bed in the lowest position.During an interview on 03/10/26 at 2:20 p.m. LVN C and the ADON was informed by the Surveyor of Resident #29 not having an intervention for her bed to be in the lowest position for fall prevention, The ADON stated Resident #29 was a fall risk and her bed was to be in the lowest position so if she fell it could reduce the risk of injury. The ADON stated the resident's bed being in the lowest position should have been an intervention included in the resident's plan of care for fall prevention so staff would be aware of her plan of care. The ADON stated the DON and MDS nurse were responsible for updating the resident's care plan. During an interview and record review on 03/11/26 at 01:15 p.m., the DON was informed of Resident #29 not being care planned for her evening eternal feed. She reviewed the resident's care plan and stated the resident should have been care planned for the eternal feed because it was part of her plan of care. She stated it was the MDS nurse and her responsibility to update the resident's care plan. She was also informed of Resident #29 not being care planned for her bed being in the lowest position. She stated she was informed of this by the ADON and she had updated the resident's care plan to include this intervention. During an interview on 03/11/26 at 02:15 p.m., the MDS nurse stated she was informed by the DON of Resident #29 not being care planned for her bed being in the lowest position and the resident receiving eternal feeding. She stated it was her and the DON's responsibility to update the resident's plan of care to ensure the resident received the care needed.Record review of the facility's policy, Comprehensive Care Plans the Compliance Store revised May 05, 2025 reflected Policy: It is the policy of this facility 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 and services that are identified in the resident's comprehensive assessment .Policy Explanation and Compliance Guidelines . 1. The care planning process will include an assessment of the resident's strengths and needs . 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment.

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	675109	A. Building B. Wing	03/12/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of hazards as was possible for ten of eleven residents (Residents #4, #7, #10, #11, #24, #31, #34, #74, #91, and #96) and for two of four LVNs (LVN B and LVN I) reviewed for accident hazards.1. The facility failed to ensure Resident #31 had her fall prevention interventions which included a fall mat to each side of bed every shift for safety. 2. The facility failed to ensure Residents #4, #10, #11, #24, #34, #74, #91, and #96 were properly supervised while smoking in the smoking area of the facility and that Resident #4, #10, #24, #34, #74, #91, and #96 had quarterly smoking assessments completed.3. The facility failed to ensure that LVN B did not leave a container of germicidal wipes on top of her cart unattended on 03/10/2026. 4. The facility failed to ensure LVN I did not leave a container of germicidal wipes on top of his cart unattended on 03/10/2026.These failures placed residents at risk of injury, pain, bruises, fractures, dislocation of joints, exposure to toxic chemicals, exposure to toxic chemicals, and/ or significant changes of condition. Findings included: 1. Record review of Resident #31's face sheet dated 03/10/26 revealed an [AGE] year-old admitted to the facility initially on 12/13/2010 with the following diagnoses: Type 2 Diabetes ((high blood sugar levels), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills), Convulsions (sudden, uncontrollable shaking or jerking of the muscles), Epilepsy (recurrent, unprovoked seizures caused by temporary, abnormal electrical activity in the brain). Record review of Resident #31's MDS dated [DATE] revealed that the resident was coded for risk of developing pressure ulcers/injuries, had severely impaired decision skills, triggered for falls, he required extensive assistance for all ADL's and all his nutrition via a feeding tube. Review of Resident #31's Treatment Administration record dated 03/01/26 to 03/31/26 revealed an order for: Fall mat to each side of bed every shift for safety, intervention was signed off as being completedReview of Resident #31's care plan dated 01/02/26 revealed the resident is at risk for falls Gait/balance problems, Unaware of safety needs, history of falling, dx of unspecified lack of coordination. Intervention noted on care plan was fall matt to each side of bed. Resident #31 was noted laying on her floor mat on 06/24/23 and 07/08/24 with no injuries noted. Observation on 03/10/26 at 1:50 pm, Resident #31 was in bed sleeping, fall mat was noted only on the right side of the bed. Interview with LVN A on 03/10/26 at 2:00 pm, she stated Resident #31's Fall mats should be in place all the time if fall mats are not in place it will result in severe injury if the resident falls. She stated it should be checked during rounds by all care staff. Interview with CNA D on 03/10/26 at 2:15 pm she stated she was not aware Resident #31 needed to have fall mats one on both sides of the bed. Not having both fall mats in place could result in serious injury with any fall. Interview with the DON on 03/10/26 at 2;25 pm, she stated that Floor mats for Resident #31 should be in place per care plan and orders, not having both fall mats in place could result in injury with fall. She stated all care staff are responsible for checking to make sure the fall mats are in place. She (continued on next page)

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	675109	A. Building B. Wing	03/12/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated she will conduct an audit and provide education to care staff on fall prevention and monitoring. 2. Record review of Resident #4's Face Sheet, dated 03/11/26, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included lack of coordination and COPD. Record review of Resident #4's Quarterly MDS assessment, dated 01/29/26, reflected he had a BIMS score of 14 (intact cognitive response). For active diagnosis it reflected respiratory failure. For ADL care it reflected the resident dependent on staff to provide care. Record review of Resident #4's Comprehensive Care Plan, dated 03/02/26, reflected the resident was a smoker and an intervention was supervised smoking sessions. Record review of Resident #4's Smoking assessment revealed it was last completed on 09/04/25. Record review of Resident #10's Face Sheet, dated 03/11/26, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included lack of coordination and COPD. Record review of Resident #10's Quarterly MDS assessment, dated 12/05/25, reflected he had a BIMS score of 15 (intact cognitive response). For active diagnosis it reflected respiratory failure. For ADL care it reflected the resident required supervision. Record review of Resident #10's Comprehensive Care Plan, dated 02/20/26, reflected the resident was a smoker and an intervention was for the resident to be supervised while smoking for safety. Record review of Resident #10's smoking assessment revealed it was last completed on 11/18/24. Record review of Resident #11's Face Sheet, dated 03/11/26, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included respiratory failure and lack of coordination. Record review of Resident #11's Quarterly MDS assessment, dated 12/03/25, reflected he had a BIMS score of 15 (intact cognitive response). For active diagnosis it reflected acute respiratory failure. Record review of Resident #11's Comprehensive Care Plan, dated 01/23/26, reflected the resident was a smoker and an intervention was for the resident to be supervised while smoking for safety. Record review of Resident #24's Face Sheet, dated 03/11/26, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included schizophrenia (severe brain disorder, and bipolar disease (mood swings) Record review of Resident #24's Quarterly MDS assessment, dated 02/11/26, reflected she had a BIMS score of 15 (intact cognitive response). For active diagnosis it reflected schizophrenia. Record review of Resident #24's Comprehensive Care Plan, dated 03/11/26, reflected the resident was a smoker and an intervention was for the resident to be supervised while smoking for safety. Record review of Resident #24's smoking assessment revealed it was last completed on 10/30/25. Record review of Resident #34's Face Sheet, dated 03/11/26, reflected he was an [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included lack of coordination and COPD (continued on next page)

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	675109	A. Building B. Wing	03/12/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(lung disease). Record review of Resident #34's Quarterly MDS assessment, dated 01/06/26, reflected he had a BIMS score of 13 (intact cognitive response). For active diagnoses it reflected lack of coordination and COPD. Record review of Resident #34's Comprehensive Care Plan, dated 01/07/26, reflected the resident was a smoker and an intervention was for the resident to be supervised while smoking for safety. Record review of Resident #34's smoking assessment revealed it was last completed on 09/06/24. Record review of Resident #74's Face Sheet, dated 03/11/26, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included COPD and lack of coordination. Record review of Resident #74's Quarterly MDS assessment, dated 02/16/26, reflected he had a BIMS score of 7 (severe cognitive impairment). For active diagnosis it reflected COPD. Record review of Resident #74's Comprehensive Care Plan, dated 02/27/26, reflected the resident was a smoker and an intervention was for the resident to be supervised while smoking for safety. Record review of Resident #74's smoking assessment revealed it was last completed on 09/06/24. Record review of Resident #91's Face Sheet, dated 03/11/26, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included acute respiratory failure and lack of coordination. Record review of Resident #91's Quarterly MDS assessment, dated 12/12/25, reflected he had a BIMS score of 15 (intact cognitive response). For active diagnosis it reflected COPD. Record review of Resident #91's Comprehensive Care Plan, dated 01/08/26, reflected the resident was a smoker and an intervention was for the resident to be supervised while smoking for safety. Record review of Resident #91's smoking assessment revealed it was last completed on 09/06/24. Record review of Resident #96's Face Sheet, dated 03/11/26, reflected she was an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included paralysis of left side of her body and lack of coordination. Record review of Resident #96's Quarterly MDS assessment, dated 02/01/26, reflected she had a BIMS score of 9 (moderate cognitive impairment). For active diagnosis it reflected lack of coordination. Record review of Resident #96's Comprehensive Care Plan, dated 02/20/26, reflected the resident was a smoker and an intervention was for the resident to be supervised while smoking for safety. Record review of Resident #96's smoking assessment revealed it was last completed on 12/09/24. During an observation and interview on 03/11/26 at 1:00 p.m., Floor Tech T was observed sitting in the dining area near the exit door looking out to the smoking area. Residents #4, #10, #11, #24, #34, #74, #91, and #96 were outside smoking tobacco products and Floor Tech T was observed looking at his phone and not observing the residents. He stated he was supposed to be monitoring the residents (continued on next page)

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	675109	A. Building B. Wing	03/12/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to ensure they did not harm themselves while smoking. During an interview on 03/11/26 at 12:55 p.m., the Social Worker was informed by the Surveyor of Resident #4, #10, #24, #34, #74, #91, and #96 not having a recent quarterly assessment on file. She stated it was the nursing staff responsibility to complete the quarterly assessments. She stated smoking assessments were needed to ensure the resident was safe while smoking. During an interview on 03/11/26 at 01:00 p.m., the DON was informed by the Surveyor of Resident #4, #10, #24, #34, #74, #91, and #96 not having a recent quarterly assessment on file. She stated it was the Social Worker's responsibility to ensure residents who smoke had quarterly smoking assessments completed to ensure the residents' conditions had not changed and it was safe for them to smoke. During an interview on 03/11/26 at 1:15 p.m., the Administrator was informed by the Surveyor of Floor Tech T being observed on his phone and not observing Resident #4, #10, #11, #24, #34, #74, #91, and #96 as they smoked their tobacco products. She stated staff were to observe residents while they smoked to ensure they did not harm themselves. She stated staff was not to be on their phones and distracted. The Administrator stated smoking assessments were to be completed quarterly for all residents that smoked to ensure it was safe for them to smoke and identify any risk for the residents. The Administrator was informed by the Surveyor of Resident #4, #10, #24, #34, #74, #91, and #96 not having quarterly smoking assessments completed. She stated it was the Social Worker's responsibility to complete quarterly assessments for residents who smoked to ensure they were smoking safely. 3. During an observation on 03/10/2026 at 3:49 PM revealed LVN B went inside a resident's room to administer medication. She closed the door when she went inside the resident's room. It was observed that a container of germicidal wipes (substance that destroys germs and microorganism) was on top of her cart that was left unattended when she closed the door. It was observed that several residents were passing by the hallway. During an interview on 03/10/2026 at 4:37 PM, LVN B said she should have placed the germicidal wipes inside the cart before leaving the cart unattended because there were confused residents and they might use them to clean their faces and eyes that could result in irritations. 4. During an observation on 03/10/2026 at 4:40 PM revealed an opened container of germicidal wipes was on top of a cart parked near the nurse's station. The cart was facing the hallway and was unattended. It was observed that there were no staff in the nurse's station. During an observation and interview on 03/10/2026 at 4:42 PM, the Infection Control Nurse told LVN B that the germicidal should be locked inside the cart before leaving the cart unattended. She then went to the other cart and took the open germicidal wipes and said LVN I was the one using the cart with an open container of germicidal wipes. She said the containers should be locked inside the carts because residents might mistakenly use them to wipe their faces. She said she would start an in-service about storing the germicidal wipes.During an interview on 03/11/2026 at 9:12 AM, LVN I said he was told about the open germicidal wipes he left on top of the cart. He said the wipes could be harmful to the residents, and he should have stored them properly before he left his cart. During an interview on 03/12/2026 at 6:59 AM, the ADON said the germicidal wipes should be stored inside the cart for safety reasons. She said residents might think they were ordinary wipes and use them to clean their eyes, nose, ears, and skin. She said it might cause irritation and toxicity. She said anything that indicated Keep out of reach of children. should be considered harmful because the facility had confused residents that may not know the outcome if the germicidal wipes were used. (continued on next page)

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	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She said the DON already started an in-service about not leaving the germicidal wipes on top of the carts. During an interview on 03/12/2026 at 7:28 AM, the DON said the germicidal wipes should be locked inside the carts and not left on top of the carts unattended. She said it should be secured inside the carts so that the residents would not be able to access the wipes that had chemicals on them. She said she was not sure what chemical was on the wipes but considering the wipes were used to disinfect, then the wipes could be harmful to the residents. She said confused residents might get hold of the wipes and wipe their face and body that could result in irritations. She said the expectation was for the staff to be mindful and never leave the germicidal wipes on top of the carts unattended. She said she already started an in-service about not leaving anything with chemicals unattended. During an interview on 03/12/2026 at 9:25 AM, the Administrator said the germicidal wipes should be placed somewhere not accessible to the residents. She said the wipes had chemicals in them that could be harmful when consumed or had contact with the eyes. She said the DON already started an in-service about not leaving the germicidal wipes unattended, but she would still coordinate with the DON to closely monitor if the staff understood the in-service. Record review of the facility's policy Medication Storage The Compliance Store revised June 15, 2025, reflected 3. External Products: Disinfectants and drugs for external use are stored separately. Record review of Safety Data Sheet (SDS) on 01/21/2026 reflected Safety Data Sheet Medline Micro-Kill Two Germicidal Wipes . Section 2. Hazards Identification . Classification . acute toxicity – oral . eye irritant . flammable liquids . Hazard Statements: Causes serious eye irritation . Flammable liquid and vapor . May cause drowsiness or dizziness . Storage: Keep out of the reach of children. Review of the facility's Fall Prevention Program dated 05/29/25 revealed: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.Record review of facility's policy, Resident Smoking, undated, reflected It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents. Residents who smoke will be further assessed, using the Resident Safe Smoking Assessment, to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **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, the comprehensive person-centered care plan, and the residents' goals and preferences for three of twelve residents (Residents #5, #6 and #15) reviewed for respiratory care. 1. The facility failed to ensure Resident #5's nasal cannula was stored properly when not in use on 03/10/2026. 2. The facility failed to ensure Resident #6's nasal cannula was stored properly when not in use on 03/10/2026. 3. The facility failed to ensure Resident #15's breathing mask was stored properly when not in use on 03/10/2026. These failures could place residents at risk of respiratory infection and not having their respiratory needs met.Findings included: 1. Record review of Resident #5's Face Sheet, dated 03/10/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with chronic pulmonary edema (accumulation of fluid in the lungs). Record review of Resident #5's Quarterly MDS Assessment, dated 01/06/2026, reflected that the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment did not indicate that the resident was on oxygen therapy. Record review of Resident #5's Quarterly Care Plan, dated 02/27/2026, reflected that the resident had pulmonary edema and one of the interventions was to administer oxygen as ordered. Record review of Resident #5's Physician Order, dated 02/26/2026, reflected Oxygen at 2 liters per minute via Nasal Cannula (flexible tube used to deliver oxygen to the nose through two prongs). Every shift for SOB. During an observation on 03/10/2026 at 2:37 PM revealed Resident #5 was in her wheelchair in the hallway and was about to be transferred to her bed. It was observed that the resident was on oxygen via a nasal cannula connected to the oxygen tank at the back of her wheelchair. When the resident was already in her bed, CNA D pulled the resident's nasal cannula from the resident's bed railing to replace the nasal cannula from her wheelchair. The nasal canula was not bagged. During an observation and interview on 03/10/2026 at 2:46 PM, CNA D said the nasal canula was not bagged and she would tell the nurse to replace it because it was already dirty. She said whoever transferred the resident should have bagged the nasal cannula. She said she did not know who transferred the resident earlier that day. During an observation and interview on 03/11/2026 at 6:22 AM revealed Resident #5 was in her wheelchair at the reception area of the facility. It was observed that the resident was using oxygen. She said she had been using oxygen for years and would use it night and day. 2. Record review of Resident #6's Face Sheet, dated 03/10/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with respiratory failure with hypoxia (insufficient amount of oxygen in the body). Record review of Resident #6's Quarterly MDS Assessment, dated 01/07/2026, reflected that the resident had a moderate impairment in cognition with a BIMS score of 11. The Quarterly MDS Assessment indicated the resident was on oxygen therapy. Record review of Resident #6's Comprehensive Care Plan, dated 01/19/2026, reflected the resident had oxygen therapy and one of the interventions was administered oxygen as ordered. Record review of Resident #6's Physician's Order, dated 10/07/2024, reflected O2 at 2-3 LPM via NC as needed for O2 Sats less than 90%. Document LPM used and O2 sats. During an observation on 03/10/2026 at 9:15 AM revealed Resident #6 was not inside his room. It was observed that a nasal canula was attached to an oxygen concentrator at the bedside. The nasal cannula was on top of the bed and was not bagged. During an observation and interview on 03/10/2026 at 9:17 AM, CNA D said Resident #6 was up early because he needed to go to his appointment. She saw the nasal cannula on top of the bed and said the nasal cannula should be bagged so that it would not get dirty. She said she would notify the nurse, so it be replaced with a new one. 3. Record review of Resident #15's Face Sheet, dated 03/10/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with congestive heart failure (condition in which the heart cannot pump blood well enough to meet the body's needs). (continued on next page)

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	675109	A. Building B. Wing	03/12/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #15's Quarterly MDS Assessment, dated 12/31/2025, reflected that the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated the resident had congestive heart failure. Record review of Resident #15's Comprehensive Care Plan, dated 01/11/2026, reflected that the resident did not have a care plan for congestive heart failure. Record review of Resident #15's Physician's Order, dated 12/29/2025, reflected Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 1 vial inhale orally three times a day for SOB/Congestion. During an observation and interview on 03/10/2026 at 9:10 AM revealed Resident #15 was in her awake. It was observed that a nebulizer machine was on top of the resident's side table with a breathing mask attached to it. The breathing mask was on top of the nebulizer and was not bagged. The resident said the nurse administered her breathing treatment, and somebody had to take it off because she was unable to put it on the side table. She said somebody took it off, but she could not remember who took it off. During an observation and interview on 03/10/2026 at 9:20 AM, LVN A said she administered Resident #15's breathing treatment but had not checked on the resident yet. She went inside the room and saw the breathing mask was on top of the nebulizer. She disconnected the breathing mask and threw it in the trash can. She said she would get a new one. She asked the resident, and the resident told LVN A that somebody took it off. She said she was also notified of Resident #6's nasal canula, and she already changed it. She said the breathing mask and the nasal canula should be bagged to prevent cross contamination and possible respiratory infection. She said she would also talk to the CNAs that when they transfer a resident with a nasal canula, make sure to bag it. During an interview on 03/12/2026 at 6:59 AM, the ADON said the nasal canula and the breathing masks should be bagged when the residents were not using them to prevent probable infection. She said whoever transferred the resident should put the nasal cannula in a bag after taking them off the residents. She said whoever administered the breathing treatment should bag the breathing mask when the treatment was done. She said they had already started an in-service about respiratory care. During an interview on 03/12/2026 at 7:28 AM, the DON said the staff were responsible for making sure the nasal cannula and the breathing masks were bagged when not in use to prevent any respiratory infection. She said the staff who transferred the residents with nasal canula should have bagged the nasal canula, and the staff who administered the breathing treatment should have bagged the breathing mask after the treatment was done. She said she already started an in-service about bagging the nasal canula and the breathing masks. During an interview on 03/12/2026 at 9:25 AM, the Administrator said the expectation was for the staff to bag the nasal cannula and the breathing mask when not in use to prevent respiratory issues. She said she would coordinate with the DON about respiratory care. Record review of the facility's policy Oxygen Administration The Compliance Store revised May 16, 2025, reflected Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice . Policy Explanation and Compliance Guidelines . 5. Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include . e. Keep delivery devices covered in plastic bag when not in use.

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	675109	A. Building B. Wing	03/12/2026

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to assess the resident for appropriateness and review the risks and benefits of grab/assist bars (smaller bars used by the person in bed to reposition themselves), with the resident or resident representative and obtain informed consent prior to installation for 4 (Resident #1, Resident #13, Resident #76, Resident #91) of 7 resident rooms observed and reviewed for grab/assist bars. The facility failed to have evidence of informed consents for Resident #1, Resident #13, Resident #76, and Resident #91 for grab/enabler bars to be placed on the bed. The facility failed to have evidence of assessments for Resident #1, Resident #13, Resident #76 and Resident #91, for risk of entrapment and ability to safely use the grab/enabler bars. These failures could affect residents who used grab/assist bars at risk of the resident/responsible party not being aware of the risks, informed consent not being obtained from the resident or responsible party, and assessments not being completed for appropriateness which could lead to injury, entrapment, feelings of restraint, or death of the resident. Findings included: Record review of Resident #1's admission Record, dated 3/11/2026, revealed a [AGE] year-old female who initially admitted to the facility on [DATE]. Resident #1 had a primary diagnosis of Metabolic Encephalopathy (syndrome of brain dysfunction caused by systemic illness, organ failure, or toxin accumulation affecting consciousness, cognition and motor function) and other diagnoses including Adult Failure to Thrive, Acute Kidney Failure, Cognitive Communication Deficit, Bipolar II Disorder (chronic mental health condition characterized by a pattern of depressive episodes and hypomanic episodes, but never full manic episodes), Anxiety Disorder (excessive, persistent, and uncontrolled worry or fear that interferes with daily life), Post-Traumatic Stress Disorder (mental health condition triggered by experiencing or witnessing terrifying, life-threatening, or traumatic events), and Dystonia (neurological movement disorder characterized by involuntary, sustained, or repetitive muscle contractions that cause twisting, repetitive movements abnormal postures). Resident #1 had diagnoses such as Unspecified Dementia (A group of symptoms that affects memory, thinking and interferes with daily life), Alkalosis (condition where body fluids have excess base [alkali] or too little acid causing blood pH to rise), Shortness of Breath, and Chronic Obstructive Pulmonary Disease (progressive, long term lung disease causes obstructed airflow, making breathing difficult) added during stay at the facility. Record review of Resident #1's Care Plan, last updated on 01/02/2026, revealed a Focus area of The resident has an ADL self-careperformance deficit Activity Intolerance, Fatigue, Impaired balance, Limited Mobility with Interventions that included .BED MOBILITY: The resident requires extensive assist by 1 staff for bed mobility. Resident #1 had Focus area of [Resident] is at Risk for injury r/t 1/4 side rail to enable assistance with bed mobility/transfers, safety with Interventions of Call light within reach. Complete appropriate assessment for enabler/side rail per facility policy. Review for continued need for side rail per facility policy. Record review of Resident #1's Annual MDS, dated [DATE], revealed a BIMS was unable to be conducted. Staff Assessment for Mental Status was conducted and resulted in a status of Severely Impaired (never/rarely made decisions). Resident #1 had self-care functional abilities rated at partial/moderate assistance required for eating, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. Self-care functional abilities rated at substantial/maximal assistance required were oral hygiene, toileting hygiene, and shower/bathe self. Resident #1 had mobility functional abilities rated at supervision or touching assistance required for roll left and right, sit to lying, and laying to sitting on side of bed. Resident #1 had mobility functional ability rated at partial/moderate assistance required for sit to stand, chair/bed-to-chair transfer, toilet transfer and tub/shower transfer. Record Review of Resident #1's Assessment list, dated 03/11/2026, revealed no (continued on next page)

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	675109	A. Building B. Wing	03/12/2026

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessment or consent related to bed rails or grab bars. Record review of Resident #1's Miscellaneous list, dated 03/11/2026, revealed no assessment or consent related to bed rails or grab bars. Observation of Resident #1's bed on 3/10/2026 at 10:40 AM revealed bilateral grab bars on the Resident's bed. The resident was not in the room; the bed was made for the day and call light was placed on the bed. Record review of Resident #13's admission Record, dated 3/11/2026, revealed a 51-year-olf female who originally admitted to the facility on [DATE] and most recent readmission on [DATE]. Resident #13 had diagnoses that included Quadriplegia (partial or total loss of function in all four limbs), Chronic Respiratory Failure with Hypoxia (long term condition where lungs cannot adequately oxygenate the blood), Chronic Obstructive Pulmonary Disease (progressive, long term lung disease causes obstructed airflow, making breathing difficult), Muscle Weakness, Altered Mental Status, Senile Degeneration Of Brain (progressive deterioration of mental abilities including memory, reasoning, and judgement associated with aging), Unspecified Intellectual Disabilities, Other Specified Extrapyramidal and Movement Disorders (range of neurological conditions including restless leg syndrome, stiff-man syndrome, writers cramp, and medication induced tremor), and Unspecified Lack of Coordination. Record review of Resident #13's Care Plan, last updated on 02/20/2026, revealed a focus area of [Resident] has an ADL self-care performance deficit with interventions last updated on 02/07/2025 including .BED MOBILITY: The resident requires total assistance by (1) staff to turn and reposition in bed. Bed rails as an enabler for turning and repositioning in bed. Bilateral 1/4 enabler bars per residents' preference. TRANSFER: The resident requires total assistance by (2) staff to move between surfaces. Record review of Resident #13's Quarterly MDS, dated [DATE], revealed a BIMS score of 9 indicating moderate impairment. Resident #13 was assessed as being completely dependent for all self-care and mobility functional abilities as she has a total loss of function in all four limbs. Record Review of Resident #13's Assessment list, dated 03/11/2026, revealed no assessment or consent related to bed rails or grab bars. Record review of Resident #13's Miscellaneous list, dated 03/11/2026, revealed no assessment or consent related to bed rails or grab bars. Observation of Resident #13's bed on 3/10/2026 at 10:05 AM revealed the resident in bed, covered with blankets, and watching tv. The resident's bed had a scoop mattress and there were bilateral grab bars observed on the bed. Record review of Resident #76's admission Record, dated 3/12/2026, revealed a [AGE] year-old male who originally admitted to the facility on [DATE]. Resident #76 had diagnoses including Anemia (blood disorder marked by a deficiency of healthy red blood cells reducing oxygen transport to body tissues), Major Depressive Disorder (mental health condition characterized by persistent, severe sadness, low mood, and loss of interest), Obstructive Sleep Apnea (disorder where upper airway collapses during sleep, causing breathing to repeatedly stop and restart), and Alcohol Abuse; no Primary admitting diagnosis was listed. Record review of Resident #76's Care Plan, last updated on 02/20/2026, revealed a focus area of Resident #76 is at Risk for injury r/t 1/4 side rail to enable assistance with bed mobility/transfers, safety and interventions of Call light within reach. Complete appropriate assessment for enabler/side rail per facility policy. Review for continued need for side rail per facility policy. Record review of Resident #76's Entry MDS, dated [DATE], revealed the resident was admitted from a short-term general hospital. No information on functional or mental status was included. Record Review of Resident #76's Assessment list, dated 03/12/2026, revealed no assessment or consent related to bed rails or grab bars. A BIMS assessment listed a score of 15 indicating resident was cognitively intact. Record review of Resident #76's Miscellaneous list, dated 03/11/2026, revealed no assessment or consent related to bed rails or grab bars. Observation of Resident #76's bed on 3/10/2026 at 10:20 AM revealed the resident in bed asleep. The resident's bed was observed with bilateral grab bars raised. The call light was within easy reach for the resident. Record review of Resident #91's admission Record, dated 3/12/2026, revealed a [AGE] year-old male who originally admitted to the facility on [DATE] with most recent readmission on [DATE]. Resident #91 was noted to have diagnoses including Epilepsy (chronic neurological disorder characterized by recurrent, unprovoked seizures (continued on next page)

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	675109	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	caused by sudden, abnormal electrical activity in the brain), Senile Degeneration of Brain (progressive deterioration of mental abilities including memory, reasoning, and judgement associated with aging, Extrapyramidal and Movement Disorder (drug induced movement disorder often caused by dopamine-blocking agents like antipsychotics resulting in muscle spasms, rigidity, tremors, or restlessness), Chronic Respiratory Failure (long term condition where the lungs cannot adequately oxygenate the blood or remove carbon dioxide), Unspecified Convulsions (sudden, involuntary, and sometimes temporary muscle contractions or jerking motions), Schizoaffective Disorder Bipolar Type (chronic mental health condition blending schizophrenia symptoms [hallucinations, delusions] with severe mood episodes [mania, depression]), Muscle Weakness (Generalized), Unspecified Abnormalities of Gait and Mobility, Abnormal Posture, and Other Muscle Spasm. Record review of Resident #91's Care Plan, last updated on 01/08/2026, revealed a focus area of [Resident] is at Risk for injury r/t 1/4 side rail to enable assistance with bed mobility/transfers, safety and interventions of Call light within reach. Complete appropriate assessment for enabler/side rail per facility policy. Educate him/her/family on risks regarding of use of side rail device. Record review of Resident #91's Quarterly MDS, dated [DATE], revealed a BIMS score of 15 indicating cognitively intact. Resident #91 was assessed for self-care functional abilities of partial/moderate assistance for lower body dressing and putting on/taking off footwear; supervision or touching assistance for toileting hygiene, shower/bathe self, personal hygiene, and upper body dressing. Assessment for mobility functional abilities for Resident #91 indicated partial/moderate assistance for sit to stand, chair/bed to chair transfer, toilet transfer, and tub/shower transfer; supervision or touching assistance for roll left and right, sit to lying, lying to sitting on side of the bed, walking 10, 50, and 150 feet. Record Review of Resident #91's Assessment list, dated 03/11/2026, revealed no assessment or consent related to bed rails or grab bars. Record review of Resident #91's Miscellaneous list, dated 03/11/2026, revealed no assessment or consent related to bed rails or grab bars. Observation of Resident #91's bed on 3/10/2026 at 10:30 AM revealed bilateral grab bars raised on the resident's bed and the resident was in bed napping. The call light was next to the resident's hand. During an interview on 3/12/2026 at 9:56AM, Resident #13 stated she had been without the ability to move either her arms or legs for a long time. Resident #13 stated that the staff check on her often, ask if she wants the tv changed to a different show, or has any needs. Resident #13 reported that the staff had to come and reposition her and will every few hours. Resident #13 stated that when she is repositioned, sometimes the grab bars are in the way of the tv viewing. Resident #13 stated that staff use the grab bars to wrap things around but she has no ability to use call light or tv remote and is no longer able to use arms or hands to reposition herself or grab items. In an interview on 3/12/2026 at 10:48AM, ADON stated that for residents to have grab bars or bed trails on their bed there needed to be an assessment for safety and mobility of the residents. ADON stated that the residents' MDS assessment would also be reviewed and areas such as the BIMS would be considered. Before grab bars or bed rails were put on a bed, the family had to be notified, a progress note entered in the resident's chart, and for the bed rails/grab bars to be care planned. ADON stated that there was a consent form that was a part of the assessment and could also be noted if a family member or responsible party gave verbal consent. ADON stated that the bed rail/grab bar was in the baseline care plan that was completed at admission and realized it had been removed but not sure when. ADON shared that there could be a risk to residents who were not assessed to be safe with grab bars/bed rails of entanglement or other dangers. In an interview on 3/12/2026 at 11:15AM the Adm stated the process for grab bars or bed rails was for an assessment for appropriateness to be conducted by nursing or rehab staff, if approved a care plan entry would be made with a timeframe to reevaluate or if they grab bars were solely for repositioning then it would be indicated as indefinite use. Adm stated that consent should also be obtained from the resident or their responsible party; the assessment and consent were located in the EHR in the Assessment tab. Adm stated that residents could face a safety hazard if not appropriate for the grab bars or bed rails. Record review of Proper Use of Bed Rails revised (continued on next page)

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	675109	A. Building B. Wing	03/12/2026

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/09/2025, revealed the policy It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails . The definition provided was: Bed Rails are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths. Also, some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed. Examplesof bed rails include, but are not limited to side rails, bed side rails, safety rails, grab bars and assist bars. Further review revealed: Policy Explanation and Compliance Guidelines:Resident Assessment1. As part of the resident's comprehensive assessment, the following components will be considered whendetermining the resident's needs, and whether or not the use of bed rails meets those needs:a. Medical diagnosis, conditions, symptoms, and/or behavioral symptoms.f. Underlying medical conditionsg. Existence of deliriumh. Ability to toilet self safelyi. Cognition.k. Mobility (in and out of bed).Informed Consent6. Informed consent from the resident or resident representative may be obtained after appropriate alternativeshave been attempted prior to installation and use of bed rails. This information should be presented in anunderstandable manner, and consent given voluntarily, free from coercion.Appropriate Alternatives9. The facility will attempt to use appropriate alternatives prior to installing or using bed rails. Alternativesinclude, but are not limited to.10. Alternatives that are attempted should be appropriate for the resident, safe and address the medical conditions,symptoms or behavioral patterns for which a bed rail was considered.

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	03/12/2026

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

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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. Based on observation, interview and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food safety in the facility's only kitchen. The facility failed to ensure food items in the refrigerator were dated, labeled, and sealed appropriately. The facility failed to ensure the ice machine was thoroughly cleaned and sanitized. The facility failed to ensure the ice scoop holder was thoroughly cleaned and sanitized. The facility failed to ensure the ice chest on the 2500-hall was thoroughly cleaned and sanitized. The facility failed to ensure the tea dispenser was covered with a lid. The facility failed to ensure the rinse temperature on the dishwasher was at the manufacturers required operating temperature of 180 degrees. These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness, and food contamination. Findings included: During Observation on 03/10/26 at 8:57 am, a tea dispenser in the facility kitchen was observed with tea in it without a lid on it. During observation on 03/10/26 at 8:59 am, a Styrofoam container with no date or name was noted in the refrigerator located in the facility kitchen. During observation on 03/10/26 at 9:05 am, the ice machine located in the kitchen was noted with black, greenish and red stains on the inside of the ice machine. During observation on 03/10/26 at 9:06 am, the Ice scoop holder in the kitchen had black discoloration on the base of it. During an observation on 03/10/26 at 09:14 a.m., an ice chest, located on the 2500-hall, had reddish and light brownish stains on the inside of the chest, which contained ice, and a metal ice scoop was sitting in the ice. During an interview on 03/10/26 at 11:40 am with [NAME] 1, he stated that he does not know who the food in the Styrofoam container belonged to. He stated that any premade food in the refrigerator should have a date on it to prevent expired food being served to the residents. During an interview on 03/10/26 at 11:43 am with Nutrition manager, he stated the tea dispenser should be closed when filled with tea to prevent contamination. He stated that the ice machine and the ice scoop holder were cleaned weekly. He stated the kitchen staff makes daily rounds to check for cleanliness of the ice machine and ice scoop holder. He stated that no staff personal or resident personal food should be in the kitchen fridge, He stated, they prepare food in advance for residents who need substitutes but that should be labelled with date and time. He stated that the ice machine and ice scoop holder not being sanitized properly could cause widespread sickness to all residents who use the ice, During an interview on 03/11/26 at 11:45 a.m., the Nutrition manager was shown a picture of the ice chest, located on the 2500-hall, which had reddish and light brownish on the inside of the chest. He stated the CNAs were to bring all the ice chests on the halls to the kitchen to be run through the dishwasher every morning and they refill it with ice. He stated it was up to the nursing staff to ensure they brought the ice chest to the kitchen to be cleaned. He stated that the ice scop should not be stored in the ice chest. He stated that not cleaning the ice chest and leaving the ice scoop in the chest could contaminate the ice and lead to residents getting sick. Observation on 03/11/26 at 12:06 pm, It was observed the dishwasher had a rinse temperature of 110 degrees when it was being run, 70 degrees lower than posted operating temperature of 180 degrees. Interview on 03/12/26 at 9:10 am with the Nutrition manager, he stated the dishwasher temperature was checked 3 times a day and temperature was logged in the temperature log. Since it was noted by the surveyor and kitchen staff that the rinse temperature was 70 degrees off the 180 degrees manufacturer's operating temperature, they had switched to a 3-compartment sink method to sanitize dishes as of 3/11/26. The Nutrition manager stated that If dishes were not properly sanitized, it will have left over food debris which could cause cross contamination of food types and make residents sick. Record review of the facility Policy on Use and Storage of Food Brought in by Family or Visitors states: It is the right of the residents of this facility to have food brought in by family or other visitors, however, The food must be handled in a way to ensure the safety of the residents. Record review of the facility policy on Date Marking for Food Safety states: The facility (continued on next page)

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	675109	A. Building B. Wing	03/12/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food.The food shall be clearly marked to indicate the date or day by which the food shall be consumed or Discarded.The individual opening or preparing a food shall be responsible for date marking the food at the time The food is opened or prepared.The marking system shall consist of a label, the day/date of opening, and the day/date the item must be consumed or discarded.The discard day or date may not exceed the manufacturer's use-by date, or four days, whichever is earliest. The date of opening or preparation counts as day 1. (For example, food prepared on Tuesday shall be discarded on or by Friday.)The Head Cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring and shall discard accordingly.The Dietary Manager, or designee, shall spot check refrigerators weekly for compliance, anddocument accordingly. Corrective action shall be taken as needed.

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	675109	A. Building B. Wing	03/12/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview and record review the facility failed to establish and 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 three of fifteen residents (Residents #5, #29, and Resident #38) reviewed for infection control. 1. The facility failed to ensure CNA D and CNA E performed hand hygiene before transferring Resident #5 on 03/10/2026. 2. The facility failed to ensure LVN B wore a gown while administering Resident #29's medication via g-tube on 03/10/2026. 3. The facility failed to ensure CNA F performed hand hygiene and changed her gloves after touching the soiled draw sheet during Resident #38's incontinent care on 03/10/2026. These failures could place residents at risk of cross-contamination and development of infections.Findings include: 1. Review of Resident #5's Face Sheet, dated 03/10/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness. Review of Resident #5's Quarterly MDS Assessment, dated 01/06/2026, reflected that the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated the resident was dependent on staff for bed-to-chair transfer. Review of Resident #5's Care Plan, dated 02/27/2026, reflected the resident required extensive assistance by two staff with mechanical lift (devices used to move a person from one position to another). During an observation on 03/10/2026 at 2:37 PM revealed CNA D and CNA E were about to transfer Resident #5 from wheelchair to the resident's bed. Both CNAs took some gloves from a box of gloves from the wall and put them on. Both CNAs did not perform hand hygiene prior to putting the gloves on. During an interview on 03/10/2026 at 2:49 PM, CNA D said hand hygiene should have been performed before transferring Resident #5 to make sure the hands were clean before touching the resident to prevent infection. She said she should have sanitized her hands before putting the gloves on to make sure her hands were clean before touching the gloves to be worn. During an interview on 03/10/2026 at 2:51 PM, CNA E said he forgot to sanitize his hands before transferring Resident #5. He said hands should be washed or sanitized before putting on a pair of gloves to prevent cross contamination and infection. 2. Record review of Resident #29's Face Sheet, dated 03/10/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with gastrostomy status (having done a surgical procedure that creates artificial opening into the stomach to provide nutritional support) and irritable bowel syndrome (abdominal disorder characterized by bloating, abdominal pain, and diarrhea). Record review of Resident #29's Comprehensive MDS Assessment, dated 01/08/2026, reflected that the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had a feeding tube (medical device that helps deliver nutrition and medication directly to the person's stomach). Record review of Resident #29's Comprehensive Care Plan, dated 01/10/2026, reflected the resident was on EBP related to g-tube (gastrostomy feeding tube: a tube that is surgically inserted through the skin of the belly and into the stomach) and one of the interventions was to the use of gowns and gloves during high-contact resident care. Record review of Resident #29's Physician Order, dated 02/03/2026, reflected Enteral Feed Order in the evening of Jevity 1.5 at 55 ml/hour via feeding tube. Up at 7pm, to run continuously until a total volume of 660 ml is administered. May remove for care and services. Record review of Resident #29's Physician Order, dated 02/03/2026, reflected Dicyclomine HCl Oral Tablet 20 MG (Dicyclomine HCl) Give 1 tablet via G-Tube four times a day for irritable bowel syndrome. Record review of Resident #29's Physician Order, dated 10/07/2026, reflected Enhanced Barrier Precautions for, (indwelling medical device) (GTube) Gown and Gloves required for HIGH-CONTACT Resident Care Activities. An observation on 03/10/2026 at 3:49 PM revealed LVN B was about to administer Resident #29's medication. She prepared the medication, crushed it, and dissolved it with water. She went inside the resident's room and administered the medication. She did not wear a gown while administering the medication. During (continued on next page)

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	675109	A. Building B. Wing	03/12/2026

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Richardson Nursing and Rehabilitation	1111 Rockingham Drive Richardson, TX 75080

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an interview on 03/10/2026 at 4:37 PM, LVN B said it did not occur to her to put on a gown when she was administering Resident #29's medication. She looked at the sign outside the resident's door and saw the gown should be used during use of g-tube. She said gowns were needed in addition to the gloves to make sure that the staff were not transferring anything dirty to the residents with tubings. 3. Record review of Resident #38's Face Sheet, dated 03/10/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with weakness. Record review of Resident #38's Comprehensive MDS Assessment, dated 02/03/2026, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident was incontinent for bladder and bowel. Record review of Resident #38's Comprehensive Care Plan, dated 12/11/2025, reflected the resident had bladder and bowel incontinence and one of the interventions was to provide peri care after each incontinent episode. An observation on 03/10/2026 at 2:09 PM revealed CNA F was about to do Resident #38's incontinent care. During the process of incontinent care, CNA F rolled the soiled draw sheet of the resident, then took the new draw sheet followed by the new brief. She did not change her gloves and performed hand hygiene after she touched the soiled draw sheet. During an interview on 03/10/2026 at 2:29 PM, CNA F said she should have changed her gloves after touching the soiled draw sheet and before touching the new draw sheet and the new brief to make sure her hands and gloves were clean before touching the new draw sheet and brief. She said hand hygiene was important to prevent cross contamination and probable UTI. During an interview on 03/12/2026 at 6:59 AM, the ADON said staff should be mindful they were not causing any spread of infection in the facility and one way to do that was to do hand hygiene before, after, and during any care. She said the staff should change their gloves after touching anything soiled to make sure the staff were not using soiled gloves when they touched the new draw sheet and brief. She said another way to prevent the spread of infection was to wear PPE when residents were on EBP. She said residents with g-tubes were on EBP to prevent any microorganism from the clothes of the staff from transferring to the residents and vice versa. She said the purpose of EBP was to prevent the spread of MDRO (Multi-Drug-Resistant Organisms: refers to microorganisms that are resistant to one or more antibiotics). She said the expectation was for the staff to practice infection control, hand hygiene, change gloves, sanitize between changing gloves, and to wear PPE when needed. She said they had already started an in-service about infection control. During an interview on 03/12/2026 at 7:28 AM, the DON said hand hygiene was the most effective way to prevent cross contamination and spread of infection. She said staff should do hand hygiene before and after any care, said gloves should be changed after touching anything soiled. She said if there was an EBP sign outside the residents' rooms, then staff were required to wear a gown in addition to gloves to protect the residents from cross contamination and probable infection. She said the expectation was for the staff to adhere to the policy of hand hygiene and infection control. She said she already started an in-service about hand hygiene and infection control. During an interview on 03/12/2026 at 9:25 AM, the Administrator said staff should always wash their hands before and after any care, change their gloves when needed, and put on a gown when the residents required EBP. She said the DON already started an in-service about infection control, EBP, and hand hygiene, but she would still coordinate with the DON to closely monitor if the staff understood the in-service regarding infection control, EBP, and hand hygiene. Record review of the facility's policy Enhanced Barrier Protection The Compliance Store revised April 10, 2025 reflected Enhanced barrier precautions (EBP) are used in conjunction with standard precautions and expands the use of PPE to donning of gowns and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with any of the following . Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO . EBP is employed when performing the following high contact resident care activities . Device care or use . feeding tube. Record review of the facility's policy Hand Hygiene The Compliance Store revised April 10, 2025, reflected Policy: All staff will perform proper hand hygiene procedures to prevent the spread (continued on next page)

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	675109	A. Building B. Wing	03/12/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of infection to other personnel, residents, and visitors . Policy Explanation and Compliance Guidelines . 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice . Before applying and after removing personal protective equipment (PPE), including gloves . Before and after handling clean or soiled dressings, linens . Before performing resident care procedures . After handling items potentially contaminated with blood, body fluids, secretions, or excretions . When, during resident care, moving from a contaminated body site to a clean body site.

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	675109	A. Building B. Wing	03/12/2026

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure that the transfer or discharge was documented in the resident's medical record for one (Resident #105) of three residents reviewed for transfers and discharges.The facility failed to accurately document Resident #105's discharge on [DATE].This failure could prevent the resident or their caregivers from receiving necessary information about the resident's support needed for further care.Findings included:Review of Resident #105's Face Sheet, dated 03/11/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with heart failure and Type 2 Diabetes (high blood sugar levels). Record review of Resident #105's 's MDS Assessment, dated 02/17/26, reflected the resident's BIMS indicated an intact cognitive response. The MDS Assessment reflected the resident had active diagnoses of heart failure and Type 2 Diabetes.Record review of Resident #105's progress notes on 02/19/26 revealed Resident left AMA. After the Surveyor inquired about the resident's discharge, the Social Worker added the following progress notes on 03/11/26, Resident did not leave AMA. Resident and resident's [family member] spoke with SW one week prior of discharge; that resident would be discharging in a week. On day of discharge SW spoke with MD regarding discharge planning and arranging for home health for safe discharge. MD was in agreeance, signed order for home health; home health arranged. Resident discharged home with family. Discharge complete.Record review of Resident #105's Discharge document on 02/17/26, revealed discharged Against Medical Advice. During an interview and record review on 03/11/26 at 11:22 a.m., the Social Worker initially stated Resident #105 had discharged from the facility against medical advice and she had forgotten to have the resident sign the AMA form upon his discharge. She stated she was busy trying to get the resident set up on home healthcare and overlooked this process. The Social Worker then stated she was reminded by the Administrator that the resident's discharge was not against medical advice. She stated the resident had planned the discharge and was discharged home and set up with home health care. She was informed of the progress notes on 02/19/26 indicating the resident had left against medical advice. She stated the progress notes and discharge document was incorrect. During an interview on 03/11/26 at 11:30 a.m., the Administrator stated she was informed of Resident #105's discharge incorrectly documented as Against Medical Advice. She stated the Social Worker had forgotten the resident's physician had approved of the discharge. She stated it was important to ensure the resident's discharge was accurately documented.During an interview on 03/12/26 at 11:56 a.m., Physician O stated Resident #105 was discharged home with home health care and not AMA. He stated he had met with the Resident and the Resident's caregiver to discuss his discharge and provided his medication upon his discharge on [DATE]. Record review of facility's policy, Transfer and Discharge, undated, reflected It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility, except in limited circumstances. This policy applies to all residents regardless of their payment source. The facility's transfer/discharge notice will be provided to the resident and resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided:a. The specific reason and basis for transfer or discharge.b. The effective date of transfer or discharge.c. The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged .

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	03/12/2026

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

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to transmit encoded, accurate, and complete MDS data to the CMS System for 2 of 11 residents (Resident #1 and Resident #65) reviewed for MDS transmission. Residents #1 and #65 Quarterly MDS assessments were completed but not transmitted within 14 days of completion. This failure could place residents at risk of not having assessments completed and submitted in a timely manner as required. The findings were: Record review of Resident #1's admission Record, dated 3/11/2026, revealed a [AGE] year-old female who initially admitted to the facility on [DATE]. Resident #1 had a primary diagnosis of Metabolic Encephalopathy (syndrome of brain dysfunction caused by systemic illness, organ failure, or toxin accumulation affecting consciousness, cognition and motor function) and other diagnoses including Adult Failure to Thrive, Acute Kidney Failure, Cognitive Communication Deficit, Bipolar II Disorder (chronic mental health condition characterized by a pattern of depressive episodes and hypomanic episodes, but never full manic episodes), Anxiety Disorder (excessive, persistent, and uncontrolled worry or fear that interferes with daily life), Post-Traumatic Stress Disorder (mental health condition triggered by experiencing or witnessing terrifying, life-threatening, or traumatic events), and Dystonia (neurological movement disorder characterized by involuntary, sustained, or repetitive muscle contractions that cause twisting, repetitive movements abnormal postures). Resident #1 had diagnoses such as Unspecified Dementia (A group of symptoms that affects memory, thinking and interferes with daily life), Alkalosis (condition where body fluids have excess base [alkali] or too little acid causing blood pH to rise), Shortness of Breath, and Chronic Obstructive Pulmonary Disease (progressive, long term lung disease causes obstructed airflow, making breathing difficult) added during stay at the facility. Record review of Resident #1's MDS list in the EHR, dated 3/12/2026, revealed a Quarterly MDS with date of 1/23/2026 in status of In Process that had the alert of ARD(Q1):01/23/26 34 days overdue. The MDS list reflected the last transmitted and accepted MDS was the Annual assessment on 10/23/2025. Record review of Resident #65's admission Record, dated 3/12/2026, revealed a [AGE] year-old male who initially admitted to the facility on [DATE] with a most recent readmission date of 08/25/2023. Resident #65 had a primary diagnosis of Anoxic Brain Damage (when the brain is completely deprived of oxygen, causing cell death within approximately 4 minutes), and other diagnoses including Unspecified Dementia (decline in mental ability such as memory loss, confusion, personality changes), Extrapyramidal and Movement Disorder (drug induced movement disorder often caused by dopamine-blocking agents like antipsychotics resulting in muscle spasms, rigidity, tremors, or restlessness), Lack of Coordination, Muscle Weakness (Generalized), Impulse Disorder, Mood Disorder Due to Known Physiological Condition, Chronic Pain Syndrome, and Schizophrenia (severe, chronic mental disorder characterized by hallucinations and/or delusions, cognitive deficits, and disorganized behavior). Record review of Resident #65's MDS list in the EHR, dated, 3/12/2026, revealed a Quarterly MDS with a date of 01/15/2026 in status of Export Ready. The MDS list revealed the last transmitted Quarterly MDS was on 10/15/2025. In an interview on 3/12/2026 at 11:27AM the MDS Nurse stated that she has been responsible for resident MDS assessments for the past 6 years and since August 2025 with this facility. The MDS Nurse stated that the EHR will alert to assessments due by a set schedule. The MDS Nurse stated that once an assessment was started the alert turned off and the system was not alerted when assessments were not completed or transmitted. The MDS Nurse stated she typically printed a hard copy of the alert list to be able to document progress status when an assessment was started but not completed and is not sure how the assessments for Residents #1 and #65 were missed. In an interview on 3/12/2026 at 1:40PM the Adm stated that the MDS Nurse was responsible for completing the Annual and Quarterly MDS assessments. The ADM stated that the expectation was (continued on next page)

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	675109	A. Building B. Wing	03/12/2026

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for each resident to be accurately assessed and for the assessment to be timely transmitted by the due date or before. The Adm was asked for a copy of the facility policy or procedures for resident assessments or MDS assessments, however no policy or procedure was provided. Record review of Long-Term Care Facility Resident Assessment Instrument 3.0 User ' s Manual Version 1.20.1, dated October 2025, revealed Assessment Schedule: An OBRA assessment (comprehensive or Quarterly) is due every quarter unless the resident is no longer in the facility. There must be no more than 92 days between OBRA assessments.

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	675109	A. Building B. Wing	03/12/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 of 7 residents reviewed for wound care (Resident #14). The facility failed to follow the facility's wound cleaning protocol for Resident #14's right heel dressing change. This failure put Resident #14 at risk of not receiving necessary treatments and a worsening of their wound.Findings included: Record review of Resident #14's face sheet revealed an [AGE] year-old admitted to the facility initially on 10/23/2025 and again on 02/16/2026 with the following diagnoses: Pressure ulcer of sacral region (The sacral region refers to the area at the very base of the spine, located just above the buttocks and directly between the two hip bone), Cognitive communication deficit, Lack of coordination, Weakness. Record review of Resident #14's MDS dated [DATE] revealed that the resident had a BIMS score of 6 (indicates severe cognitive impairment). Review of Resident #14's Physician Order dated 03/10/26 revealed Xeroform Oil Emulsion Gauze External Pad (BismuthTribromophenate-Petrolatum), Apply to right heel topically every day shift for treatment, cleanse with normal saline or wound cleanser, pat dry and apply xeroform and bordered gauze. Review of Resident #14's care plan dated 02/17/26 revealed the resident has a potential for infection/complication related to wound infection, altered skin integrity, non-pressure related due to arterial wound (painful injuries in your skin caused by poor circulation) to right heel. Observation and Interview with Wound Nurse on 03/11/2026 from 9:25 am to 10:05 am. The Wound Nurse cleansed the inside of the heel wound and outer edge with the same gauze. When asked about the danger of doing so, she stated it would spread infection from the inside of the wound to the outer perimeter of the wound and could delay wound healing or make it worse. Interview with DON on 03/12/26 at 10:30 am, she stated the Wound Nurse should use a gauze only once, one gauze to cleanse the inside of the heel wound and one gauze for the outside of the wound to prevent contamination and possible spread of infection which would negatively impact the resident. She stated they will be conducting more training on wound care and infection control. Record review of the facility's infection prevention and control program document on page 21 revealed that wound care should be provided in a manner to prevent contamination of the wound bed and wound supplies. Record review of the facility's wound cleaning procedure revealed to clean from the cleanest area to the dirtiest area, cleaning from the center of the wound toward the edges. Cleaning motion starts at wound center, wipe outward toward edges, use one gauze per stroke, discard gauze after each pass.

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	03/12/2026

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

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary treatment and services, based on the comprehensive assessment and consistent with professional standards of practice, to prevent development of pressure injuries for 1 of 7 residents reviewed for pressure injuries. (Resident #31) The facility failed to apply foam boots to bilateral heel to prevent pressure ulcer for Resident #31. This failure can place the residents at risk for new development pressure injuries and could result in a decline in health. Findings included: Record review of Resident #31's face sheet dated 03/10/26 revealed an [AGE] year-old admitted to the facility initially on 12/13/2010 with the following diagnoses: Type 2 Diabetes ((high blood sugar levels), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills), Convulsions (sudden, uncontrollable shaking or jerking of the muscles), Epilepsy (recurrent, unprovoked seizures caused by temporary, abnormal electrical activity in the brain). Record review of Resident #31's MDS dated [DATE] revealed that the resident was coded for risk of developing pressure ulcers/injuries, had severely impaired decision skills, triggered for falls, he required extensive assistance for all ADL's and all his nutrition via a feeding tube. Review of Resident #31's Treatment Administration record dated 0301/26 to 03/31/26 revealed an order for: Apply foam boot to bilateral heel every shift for: to prevent pressure ulcer which was signed off as being done every shift. Review of Resident #31's care plan dated 01/02/26 revealed the resident has potential for injury development related to immobility. Observation on 03/10/26 at 1:50 pm, Resident #31 was in bed sleeping, no foam boots was in place to bilateral heels, skin on heel looks intact. Interview with LVN A on 03/10/26 at 2:00 pm. She stated that all facility staff were responsible for checking on residents to make sure care and orders and care plans were carried out, however, as charge nurse she facilitates the care. She stated the foam boots were necessary to prevent pressure injuries since the resident was bedbound. Interview with CNA D on 03/10/26 at 2:15 pm she stated she did not know Resident #31 had an order for foam boots. She stated that if she notices the foam boots were not in place, she needs to put them on and if unable to find them she lets the nurse know to find a replacement. She stated it was important to have them on as ordered to prevent pressure injuries. Interview with the DON on 03/10/26 at 2:25 pm, she stated that the foam boots need to be in place to prevent pressure ulcers from developing and it was the responsibility of all care staff to make sure it was in place during rounds and if they don't have one to let her know. She Stated has spoken to hospice nurse to make the foam boots PRN since the resident has no skin issues at this time. She stated that a plan of correction and education with be implemented with all care staff. Review of the facility's pressure injury prevention and management dated 06/01/25 revealed: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. Interventions will be documented in the care plan and communicated to all relevant staff.

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	675109	A. Building B. Wing	03/12/2026

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview, and record review the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infection and to restore continence to the extent possible for one of five residents (Resident #44) reviewed for catheter care. The facility failed to ensure Resident #14 had orders for her catheter. This failure could place residents with catheter at risk for urinary tract infection and other catheter- associated complications.Findings included: Record review of Resident #14's Face Sheet, dated 03/10/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with neuromuscular disfunction of the bladder (the muscles and nerves that control the bladder do not work properly due to illness). Record review of Resident #14's Comprehensive MDS Assessment, dated 01/29/2026, reflected that the resident had a severe impairment in cognition with a BIMS score of 06. The Comprehensive MDS Assessment indicated the resident had an indwelling catheter (a thin, flexible tube inserted in the bladder to allow the urine to flow in the catheter's bag). Record review of Resident #14's Comprehensive Care Plan, dated 02/09/2026, reflected the resident had alteration of bladder related to Foley (device used to help drain urine from bladder) and one of the interventions was to catheter care per shift. Record review on 03/10/2026 of Resident #14's Physician Order reflected no order for catheter care. Record review on 03/10/2026 of Resident #14's Physician Order reflected no order for when to empty the catheter bag. Record review on 03/10/2026 of Resident #14's Physician Order reflected no order to monitor signs and symptoms of infection such as fever, pain, and cloudy or foul-smelling urine. Record review on 03/10/2026 of Resident #14's Physician Order reflected no order to monitor for dysuria and hematuria. Record review on 03/10/2026 of Resident #14's Physician Order reflected no order to monitor the color of the urine. Record review on 03/10/2026 of Resident #14's Physician Order reflected no order to monitor for leakage. Record review on 03/10/2026 of Resident #14's Physician Order reflected no order to ensure the catheter was secured to prevent pulling. During an observation and interview on 03/10/2026 at 9:21 AM revealed Resident #14 was in her bed, awake. It was observed that the resident had a catheter. When asked how long she had her catheter, the resident did not reply. During an interview on 03/10/2026 at 9:28 AM, CNA F said Resident #14 had a catheter since she was admitted to the facility. She said she would empty the catheter's bag before the end of her shift. During an observation and interview on 03/11/2026 at 1:07 PM, LVN C said if a resident had a catheter, then there should be orders for the resident's catheter care. He opened the resident's profile and saw the resident did not have any order for her catheter. He said he knew the resident had a catheter but did not pay attention to the orders. He said there should be orders for anything done for the residents. He said there should be orders for catheter care, when to empty it, what to assess, to make sure the catheter was secured. He said he would put the orders for the resident's catheter. He said he did not know why he missed it. During an interview on 03/12/2026 at 6:59 AM, the ADON said if the resident was admitted with the catheter, there should be orders for catheter care, checking for patency, and what to assess. She said if the resident went to the hospital and was re-admitted to the facility with a catheter, then the admitting nurse should have placed the orders for the catheter. She said, maybe what happened was when the Resident #14 was sent out to the hospital, her orders were discontinued, and when the resident was re-admitted , the orders were not placed on the resident's MAR. She said, still it was an oversight because everything done for the resident should have an order. She said there could be new nurses that did not check the catheter because there was no order for it. She said it was also an oversight on her part because she did not follow through when the resident was re-admitted to the facility. During an interview on 03/12/2026 at 7:28 AM, the DON said there should be orders for everything done for the resident to ensure the proper standard of care was provided. She said the issue was not that the (continued on next page)

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	675109	A. Building B. Wing	03/12/2026

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident went out to the hospital, and the orders for the catheter needed to be discontinued. The issue was when the resident was re-admitted to the facility; the orders for the catheter were not re-entered to Resident #14's treatment administration record. She said the orders should have been placed to make sure the appropriate care was provided. She said without the orders, how could it be ensured that the staff were reminded to do and assess the residents with a catheter? She said it was the admitting nurse's responsibility to input the orders, but it was her responsibility, and the ADON's to check the record of the resident the following day of the re-admission. She said she already did an in-service about physician orders and to ensure care was being done for the residents with a catheter. During an interview on 03/12/2026 at 9:25 AM, the Administrator said the expectation was that everything done for the residents had orders. She said there should be orders for treatment, medications, diet, and therapy. She said the DON already started an in-service about making sure there were orders for catheter care, but she would still coordinate with the DON to closely monitor if the staff understood the in-service regarding inputting physician orders. Record review of the facility's policy Catheter Care The Compliance Store revised May 05, 2025, reflected Policy: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care . Policy Explanation: 1. Catheter care will be performed every shift and as needed by nursing personnel. Record review of the facility's policy Medication Orders The Compliance Store revised June 15, 2025, reflected Policy Explanation and Compliance Guidelines . 1. Medications should be administered only upon the signed order of a person lawfully authorized to prescribe . 3. Elements of the Medication Order: a. Date and time the order is written. b. Resident's full name. c. Name of medication. d. Dosage strength of medication is included. e. Time or frequency of administration. f. Duration or stop date, (e.g., antibiotics), if applicable. g. Route of administration. h. Type/Formulation (if applicable). i. Hour of administration (if applicable). j. Diagnosis or indication for use. k. PRN (as needed) orders should also specify the condition, for which they are being administered, (e.g., as needed for sleep) . 4. Documentation of Medication Orders: a. Each medication order should be documented with the date, time, and signature of the person receiving the order. The order should be recorded on the physician order sheet, and the Medication Administration Record (MAR).

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	675109	A. Building B. Wing	03/12/2026

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **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 receiving enteral feeding received appropriate care and services to prevent complication of enteral feeding for 1 out of 7 residents (Resident #31) reviewed for enteral feeding. Resident #31 was not provided with an abdominal binder for G-tube site protection as ordered. This failure could place residents with a G-tube at risk of increased risk for infection and complications. Findings included: Record review of Resident #31's face sheet dated 03/10/26 revealed an [AGE] year-old admitted to the facility initially on 12/13/2010 with the following diagnoses: Type 2 Diabetes ((high blood sugar levels), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills), Convulsions (sudden, uncontrollable shaking or jerking of the muscles), Epilepsy (recurrent, unprovoked seizures caused by temporary, abnormal electrical activity in the brain). Record review of Resident #31's MDS dated [DATE] revealed that the resident had severely impaired decision skills; she required extensive assistance for all ADL's and all his nutrition via a feeding tube. Record review of Resident #31's physician order dated 03/31/26 revealed an order for: Abdominal Binder every shift. Review of Resident #31's care plan dated 01/02/26 revealed the resident has a tube feeding Dysphagia, Swallowing problem/NPO. Intervention noted on care plan was abdominal binder initiated on 12/12/24 and revised on 02/07/25. Observation on 03/10/26 at 1:50 pm revealed, Resident #31 was in bed sleeping, no abdominal binder was in place, the GT was not protected as ordered. Interview with LVN A on 03/10/26 at 2:00 pm she stated everyone was responsible for checking on residents to make sure care and orders and care plans were carried out. However, as charge nurse she facilitates the care. She stated that Abdominal binder should be in place to prevent Resident #31 from pulling on their GT which could lead to unnecessary hospitalization for reinsertion. Interview with CNA D on 03/10/26 at 2:15 pm she stated the nurse was responsible for checking to make sure the abdominal binder was in place. Interview with the DON on 03/10/26 at 2;25 pm, she stated the abdominal binder needed to be on at all times to prevent Resident # 31 from pulling GT out. Pulling GT out could result in injury, infection, and sepsis. She stated that all care staff are responsible to ensure the abdominal binder is in place during rounds. She stated she will conduct an audit and provide education to care staff on fall prevention and monitoring.

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	675109	A. Building B. Wing	03/12/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 8 residents (Resident #39) reviewed for administration of all drugs. The facility failed to ensure Resident #39's morning medications were recorded on the resident's MAR once administered to the resident on 03/03/26. This failure could place residents at risk of receiving duplicate medication and being overly medicated.Findings included: Record review of Resident #39's Face Sheet, dated 03/11/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #39 had a diagnosis of heart disease. Record review of Resident #39's MDS Assessment, dated 01/08/26, reflected the resident's BIMS indicating an intact cognitive response. The MDS Assessment reflected the resident had active diagnoses of hypertension (high blood pressure) and dementia (loss of memory). Record review of Resident #39's Physician orders, dated 03/11/26, reflected Amlodipine tablet 5 mg. Give 1 tablet by mouth 1 time a day. Carvedilol tablet 25 mg. Give 1 tablet by mouth 2 times a day for hypertension. Clonidine HCl .01 mg. Give 1 tablet by mouth 2 times a day for hypertension.Record review of Resident #39's MAR, dated 03/03/26, reflected the resident was not administered her prescription for Amlodipine, Carvedilol, and Clonidine during the morning medication administration. During an interview and record review on 03/11/26 at 10:50 a.m., LVN D was informed of Resident #39's MAR indicating the resident did not receive her medication Amlodipine, Carvedilol, and Clonidine during the morning medication administration on 03/03/26. She stated she was unsure if the medication was missed or given and not checked off in their system of record. She stated she would have to research the issue further. She stated if the resident had not received her medications, it could have a negative impact on her health and if the medication was given but not updated in the system, it could result in the resident receiving double medication if staff thought she had not received it. During an interview on 03/11/26 at 12:00 p.m., the ADON was informed of Resident #39's MAR indicating missed medication on 03/03/26. She stated she was informed of this concern by LVN D, and she stated she administered the resident her Amlodipine, Carvedilol, and Clonidine on the morning of 03/03/26, but had forgotten to update the resident's MAR. The ADON stated she was sure the resident had received her medication. She stated if the medication was given but not updated in the system, it could result in the resident receiving double medication, if staff thought she had not received it. During an interview on 03/12/26 at 11:00 a.m., the DON stated she was informed by the ADON of Resident #39 being administered her medication of Amlodipine, Carvedilol, and Clonidine on the morning of 03/03/26, but had forgotten to update the resident's MAR. She stated the ADON was written up for failing to update the resident's MARS because the resident could have received a double dose of the medication and suffer health complications. She stated staff had to update the resident's MAR once the medication was administered to the resident. Record review of the facility's policy on Medication Administration, undated, revealed, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Administer medication as ordered in accordance with manufacturer specifications. Sign MAR after administered. For those medications requiring vital signs, record vital signs onto the MAR.

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	675109	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for one of twelve residents (Resident #90) and one (Medication Aide's Cart) of three carts reviewed for medication storage. 1. The facility failed to ensure Resident #90 did not have any medications inside her room on 03/10/2026. 2. The facility failed to ensure probiotics were refrigerated as per instruction of the manufacturer on 03/11/2026. These failures could place the residents at risk of accidental overdose, misuse of medications, not receiving the medication's full therapeutic benefits, and possible adverse reactions.Findings included: 1. Record review of Resident #90's Face Sheet, dated 03/10/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dementia (a condition characterized by loss of memory and ability to reason). Record review of Resident #90's Comprehensive MDS Assessment, dated 12/29/2025, reflected that the resident had severe impairment in cognition with a BIMS score of 02. The Quarterly MDS Assessment indicated that the resident had dementia. Record review of Resident #90's Comprehensive Care Plan, dated 02/20/2026, reflected the resident had impaired cognitive function and one of the interventions was to administer medications as ordered. Record review on 03/10/2026 for Resident #90's Assessment Notes reflected that the resident did not have an assessment for self-administration of medications. During an observation 03/10/2026 at 9:27 AM revealed Resident #90 was not inside her room. It was observed that four tubes of medication were on top of the resident's drawer. The tubes of medications were hydrocortisone, Neosporin, betamethasone cream, and pain-relieving cream. The medications were on a plain view and could easily be reached. It was also observed that one of the pain-relieving tubes was on a mug along with the toothpaste and the toothbrush. During an observation and interview on 03/10/20206 at 10:44 AM, MA G said there should not be any form of medications inside the residents' rooms because the residents might use them inappropriately. She went inside Resident #90's room and saw the tubes of medications on the resident's table. She said one of the tubes was a pain reliever and was beside the toothpaste, and the resident might mistakenly use the pain reliever's medication to brush her teeth and might cause discomfort. She said she would tell the nurse about the medications inside the resident's room. During an interview on 03/10/2026 at 9:48 AM, LVN A said she was notified that there were medications inside Resident #90's room. She said she did not notice the medications when she made her morning round. She said there should be no medications inside the resident's room to prevent misuse of the medication. She said confused residents might consume them resulting in adverse reactions such as eye irritation and stomach upset. During an interview on 03/10/2026 at 2:38 PM, Resident #90said the tubes of creams had always been on top of her table. She said she did not know why the staff did not see them 2. During an observation and interview on 03/11/2026 at 3:25 PM revealed a bottle of probiotics, with an open date of 02/23/2026, was inside the medication cart. The bottle of probiotics had a direction at the back that said, Refrigerate after opening. It was also observed that MA H read the instruction and said the probiotics should be returned inside the refrigerator after medication administration. During an observation and interview on 03/12/2026 at 3:28 PM, the Infection Control Nurse said if the instruction said to refrigerate after opening, then the bottle of probiotics should be inside the refrigerator after giving them to the residents. She took the bottle of probiotics from MA H and said she would discard it because the instruction to refrigerate was not followed, and the effectiveness of the medication was less. She said she would also get the probiotics from the other medication aide cart and would do the same. During an interview on 03/12/2026 at 6:59 AM, the ADON said medicated (continued on next page)

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	675109	A. Building B. Wing	03/12/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	creams should not be inside the residents' rooms because confused residents might use them inappropriately. She said residents with poor eyesight could mistakenly think the medicated cream was toothpaste and use them. She said the staff were responsible for making sure there were no medications inside the room. She said the staff needed to monitor more, especially if they knew that family members were bringing medications. She said they would also educate the family regarding bringing medications to the facility. She said the probiotics should be stored in a cool place to be effective. She said they already replaced the probiotics that were stored inside the cart and gave instructions to put the probiotics back inside the refrigerator after administering the medication. She said they already started an in-service about checking the rooms for any medications and following the instructions of the manufacturers pertaining to specific medications. During an interview on 03/12/2026 at 7:28 AM, the DON said medications should not be inside the rooms of the residents because it could cause probable harm such as overmedication, undermedication, or allergic reactions. She said the residents should have an assessment of self-medication to determine if they were able and if it was safe for the residents to administer their own medications. She said if the instruction for the probiotics was to refrigerate after opening, then it should not be in the cart from morning until afternoon. She said if probiotics that had instructions to refrigerate were not refrigerated, the medication would be less effective. She said the expectation was for the staff to make sure there were no medications inside the room and to follow the instructions on how to store medications. She said she had already started an in-service about medication storage. During an interview on 03/12/2026 at 9:25 AM, the Administrator said the expectation was for the probiotics to be stored inside the refrigerator when the staff were done administering them and that the scan the room of the residents for any medications. She said residents could not administer any medication with an assessment that it would be safe for the residents to take the medications by themselves. She said the DON already started an in-service about medication storage, but she would still coordinate with the DON to closely monitor if the staff understood the in-service regarding no medication inside the rooms of the residents and to properly store medications to maintain the effectiveness of the medication. Record review of the facility's policy Medication Storage The Compliance Store revised June 15, 2025 reflected Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient . temperature . Policy Explanation and Compliance Guidelines . 1. General Guidelines . a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls . b. Only authorized personnel will have access to the keys to locked compartments . 6. Refrigerated Products . a. All medications requiring refrigeration are stored in refrigerators located in the pharmacy andat each medication room.