

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/24/2025
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents were free from accident hazards for 3 of 8 residents reviewed for accidents (Resident #1, Resident #2, and Resident #3.) Resident #1 had a fall on the facility van, Van Driver A did not call 911 for assistance, and he did not report the incident to the facility. The resident was not sure of the date or time frame, and the facility could not provide a time frame. Resident #2 complained of Van Driver A's unsafe and erratic driving. Resident #3 was not strapped into the van correctly and her wheelchair tipped over backward which caused her to hurt her head, hand, and arm. This noncompliance was identified as PNC (past non-compliance) Immediate Jeopardy. The noncompliance was corrected prior to entrance. This facility failure placed Residents at risk for serious injury. Findings included: Resident #1 Record review of Resident #1's face sheet indicated she was a [AGE] year-old female admitted to the facility on [DATE]. Record review of Resident #1's MDS indicated her cognitive status was intact with a BIMS score of 13. She used a wheelchair for ambulation. She was dependent on staff for standing from a sitting position, and she was dependent on staff for transfer from bed to chair or chair to bed. Record review of Resident #1's care plan dated 9/18/25 indicated the resident had dialysis treatment due to diabetes, and end stage renal disease three times a week. The goal was the resident would not have unrecognized complications related to dialysis. Record review of Resident #1's nursing notes did not indicate any falls from January 2025 to present at dialysis or on the van, and there were no incident reports indicating an incident occurred. During an interview on 9/18/25 at 4:39 p.m. Resident #1 said about 6 months ago during transportation to dialysis, Van Driver A was trying to miss hitting a car. Resident #1 said Van Driver A swerved and she fell to the floor of the van. She said she hurt her foot and tore a hole in her sock. She said there was a place on her foot. She was not taken to the hospital, and she did not hit her head. Resident #1 said Van Driver A did not hit anything, he braked hard, and she fell to her knees. During an interview on 9/18/25 at 4:47 p.m. the Administrator said Van Driver A was terminated due to taking shortcuts, and complaints of erratic driving. The Administrator Van Driver A had not reported any incidents that occurred on the van with Resident #1. He said Resident #1 had not reported any incident that occurred on the van. During an interview on 9/23/25 at 10:50 a.m. the DON said she had talked to Resident #1 about the incident a few days ago and she said she had fallen on the van several months back. She said the resident did not have an exact time frame. The DON said she was not aware of the fall and Van Driver A had not reported any falls. The DON said Resident #1 said the nurses at dialysis had gotten her off the van floor. The DON said Resident #1 was not able to walk and required assistance with transfers. She said they did not receive a report from Van Driver A, no report from dialysis clinic, and Resident #1 had not reported the incident. During an interview on 9/23/25 at 11:00 a.m. the Administrator said he had received complaints from outside individuals calling about Van Driver A's erratic driving. The Administrator said the callers reported Van Driver A was speeding, and changing lanes frequently. The Administrator said Van Driver A denied there was any previous incident of a resident falling on the van. During a telephone interview on 9/23/25 at 1:48 p.m. Van Driver A said he did not remember Resident #1 falling while on the van during transport. During an interview on 9/24/25 at 10:05 a.m. Resident #1 said she remembered falling out of the wheelchair when Van Driver A did not put the seatbelt on her during transportation to her dialysis appointment. She said he was coming around a corner or something, but he hit the brakes, and she slid out of the wheelchair. She said she hit the floor and the nurses at the dialysis clinic came on the van and got her off the van floor. She remembered the incident but could not provide a time frame. She said it may have been 4 or 5 months ago. Resident #1 said she hurt her foot. She said she did not tell anyone because the nurses at the dialysis clinic knew, so when she came back to the facility, she did not tell the facility nurses. She said her wheelchair did not fall or tilt over, she just slid out of the chair. Resident #1 said the wheelchair was still strapped down. During an interview on 9/24/25 at 10:50 a.m. the Clinical Coordinator/RN[at the dialysis clinic said she remembered the incident when Resident#1 had fallen on the van. She said she looked, and they did not have any notes. She said she was not there and could not find any staff that were working today that were present when the incident happened. She said she remembered it was on a Saturday and between her and the staff that were at the clinic today, they thought it was about two months ago. The Clinical Coordinator said she was not there but remembered the staff talking about Resident #1 falling on the van and they had to go and pick her up off the van floor. Resident #2 Record review of</p>		