

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676448	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF PROVIDER OR SUPPLIER The Reserve at Richardson		STREET ADDRESS, CITY, STATE, ZIP CODE 1610 Richardson Dr Richardson, TX 75080	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42824</p> <p>Based on observations, interview, and record review, the facility failed to ensure resident received adequate supervision to prevent Resident #1's accidents from an elopement for (Resident #1) 1 of 6 residents reviewed for wandering, elopement, accidents, hazards, and supervision.</p> <p>On 01/26/2025, the facility failed to identify potential hazards and follow internal systems in place for Resident #1 to prevent her from exiting thru unlocked doors located in the dining area leading to a corridor land fire exit door which connected to a stairwell where she experienced an unwitnessed fall down the stairs and sustained multiple serious injuries that included right wrist and extensive facial fractures.</p> <p>A Past Non-Compliance Immediate Jeopardy (PNC IJ) was identified and presented to the Administrator and DON on 03/10/2025 at 3:30 PM. The noncompliance began on 01/26/2025 and ended on 02/02/2025. The facility corrected the noncompliance before the investigation began.</p> <p>This failure could place residents at the facility at risk of injury and a decreased quality of life, significant harm, or death.</p> <p>Findings Included:</p> <p>Review of Resident #1's Face Sheet dated 03/10/2025 revealed she was an [AGE] year-old female admitted to the facility on [DATE] from an acute care hospital. Relevant diagnoses included dementia, major depressive disorder, osteoporosis (loss of bone density causing brittle bones,) repeated falls, and cognitive communication deficit.</p> <p>Review of Resident #1's Admission MDS dated [DATE] revealed she required corrective lenses and was severely cognitively impaired with BIMS score of 04. She required a walker and/or wheelchair for mobility and required supervision for toilet, tub, and/or shower transfers. Resident #1's MDS revealed no documentation of acute change in mental status and she had no behavioral symptoms of hallucinations, delusions, or physical or verbally aggressive behavior directed towards others.</p> <p>Review of Resident #1's Comprehensive Care Plan dated 01/31/2025 revealed she was at risk for falls related to a history of falling and at risk for wandering and elopement.</p> <p>Interventions for falls included:</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 - Few</p>	<ul style="list-style-type: none"> -Anticipate needs -Ensure call light was within reach and to encourage Resident #1 to use for assistance -Educate resident, family, caregivers about safety reminders -Encourage Resident #1 to participate in activities that promote exercise, physical activity -Ensure Resident #1 has appropriate footwear -Follow safety protocol -Therapy evaluate and treat as ordered and as needed <p>Interventions for wandering and elopement included:</p> <ul style="list-style-type: none"> -Clearly identify Resident #1's room and bathroom -Engage resident in purposeful activity -Schedule time for regular walks and appropriate activity <p>Review of facility Provider Investigation Report date 02/07/2025, submitted by facility DON revealed: [Resident #1] is a [AGE] year old female who admitted to the [Facility] on 1/6/25 . Resident diagnosis history include dementia, dysphagia, other abnormalities of [NAME] and mobility, repeated falls, [multiple organ dysfunction,] osteoporosis and recent fall in December 2024 with [right] clavicle fracture and 2 [right] rib fractures. Resident is alert and oriented [to person and herself,] able to voice needs and follow direction. [BIMS] score 3. At baseline; resident uses rolling walker to ambulate and walk around the hallways of the facility several times throughout the day . [Resident #1] was resting in bed most of the day watching tv. She ate her meals and the staff assisted her with toileting. At approximately 2:30pm, resident was seen ambulating around the hallways like she is usually and was smiling and talking with the other residents. She would be sitting in her room on the bed and then ambulate to the dining room and sit at a table looking out the window. Staff noted resident had a runny nose after dinner time and completed covid test with the result of negative. No other signs or symptoms noted. Vital signs stable. Resident stated she felt fine and no issues. Resident walked to room from dining room several times after dinner and was checked on frequently by staff and all needs met. At approximately 6:50, [CNA a] went through the foyer area to the breakroom to use the restroom. At 6:55, [CNA A] heard emergency alarm ringing. She quickly completed her task and rushed to the alarm that was still sounding and resident observed laying on the floor of hallway. Alerted nurse [LVN Z] and other staff immediately who administered first aid.</p> <p>Review of Resident #1's Hospital Clinical Records after the incident on 01/26/2025, dated 01/30/2025, revealed she had a fall down 3 steps and her injuries included:</p> <ul style="list-style-type: none"> -Right non-displaced distal radius fracture (wrist area) -Extensive bilateral facial fractures (fracture of the bones of the face on both sides) <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In review with the facility's ADON C on 03/06/2025 at 1:22 PM, she stated she was familiar with Resident #1 and her care needs that included frequent monitoring, re-direction, and fall precautions. She stated she took care of Resident #1 a couple days before her incident and she was at her baseline, which was pleasantly confused. She stated staff kept her close to the nurse's station for close monitoring because of her fall history and wandering risk. She stated the incident on 01/26/2025 was right after dinner service and CNA A found her within minutes of when the incident occurred. She stated Resident #1 was sent promptly out to the hospital and returned a few days later. She stated when Resident #1 came back from her hospital stay, her room was moved closer to the nurse's station, her care plan updated to engage Resident #1 in activities and have even more monitoring to ensure her safety. She stated Resident #1's condition was bruised up upon her return to the facility and that she had an order for a brace for a wrist fracture. She stated leadership conducted multiple in-services, an elopement drill, and a keypad lock was installed on the initial door Resident #1 exited out from. She stated Resident #1 has not had any further incidents or accidents since her return and her safety has been intact.</p> <p>In interview with facility's DON on 03/07/2025 at 2:32 PM, she stated that Resident #1's care needs that included frequent monitoring, re-direction, and fall precautions. She stated these care needs were appropriately assessed and accounted for on Resident #1's assessments and comprehensive care plan. She stated facility staff were aware of Resident #1's care requirements and made their best attempts to accommodate the resident's needs without violating her resident rights. She stated the facility did everything she could to protect the resident and adhered to the [Centers for Medicare and Medicaid] critical pathway while planning Resident #1's care at the facility. She stated prior to the incident, residents had never attempted to go through the door located near the dining area and did not need to be secured. She stated an incident of this nature had never occurred at the facility to her knowledge. She stated after the incident, a multi-digit keypad lock was installed on the initial door Resident #1 exited out from to ensure no other residents were able to access this area in the future. DON further stated in response to the incident, that multiple in-services were provided to staff related to abuse, neglect, exploitation, physical environment and door alarms, wandering/elopement, and location of and the purpose of the facility's elopement binder. To conclude the in-service and training, a facility-wide elopement drill was conducted on 02/02/2025 to ensure all of the interventions the facility were practices and able to be implemented post incident to ensure Resident #1 and the other residents at the facility would be safe in their care. She stated again this incident was unforeseeable, but the facility took swift and comprehensive action afterwards to ensure resident safety moving forward.</p> <p>In interview with facility's Administrator on 03/10/2025 at 11:45 AM, he stated he was familiar and accommodating of Resident #1's care needs that included frequent monitoring, re-direction, and fall precautions. He stated the facility did their best to assess and accommodate Resident #1's needs but this incident was unforeseeable. He stated he worked very diligently to find appropriate interventions to manage Resident #1's behaviors. The day of the incident the DON called him to notify him of the incident. He stated the physical environment and doors were checked that night to ensure proper functionality. He stated the next day, a keypad lock was installed on the initial door Resident #1 exited though. He stated multiple in-services related to abuse, neglect, exploitation, physical environment and door alarms, wandering/elopement, and location of and the purpose of the facility's elopement binder were provided to staff; and a facility-wide elopement drill was conducted on 02/02/2025 to conclude all of the interventions the facility implemented post incident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interviews conducted with Administrator, DON, ADON A, ADON B, CNA C, CNA F, PTA D, LVN E, LVN G, LVN H on 03/06/2025, 03/07/2025, and 03/10/2025 between 9:00 AM - 5:00 PM, revealed no evidence that Resident #1 displayed behaviors outside of her baseline.</p> <p>Review of facility in-service and elopement drill, Preparation for Mock Elopement Drill, dated 02/02/2024 included objectives that included preparation for a mock elopement drill, elopement drill, expected response, and a detailed multi-step elopement procedure check list evaluated by the facility's DON. Approximately 25 staff signatures were observed on the attendance record.</p> <p>Review of facility's Elopement Binder on 03/10/2025 at 2:25 PM revealed Resident #1 was included with a clear picture, face sheet, and other pertinent demographic information.</p> <p>In observation of the facility's doors on 03/06/2025 at 1:22 PM, a keypad lock was present on the first door located within the facility dining room area. The next door beyond, where the emergency fire door exit was located, was observed and tested to ensure functionality.</p> <p>In interview with Administrator, DON, ADON A, ADON B, CNA C, CNA F, PTA D, LVN E, LVN G, LVN H on 03/06/2025, 03/07/2025, and 03/10/2025 between 9:00 AM - 5:00 PM, they stated Resident #1's required frequent monitoring, re-direction, and fall precautions. Her interventions included relocating Resident #1's room closer to the nurses station, proper footwear for Resident #1, promoting physically focused activities and other enrichment activities, along with enhanced monitoring to ensure Resident #1's safety . They stated an elopement drill was conducted on 02/02/2025 with education provided on abuse, neglect, and exploitation. Additionally, Resident #1 had no incidents, accidents, or falls since the incident on 01/26/2025.</p> <p>In review of facility's Provider Investigation Report, dated 02/07/2025, provider actions taken post-incident included: abuse/neglect, in-service completed safe surveys completed with no adverse findings; elopement risk assessment updated; all doors checked by maintenance supervisor on 1/27/25 with no adverse findings elopement drill completed on 2/3/25 and to be completed quarterly or as needed. All findings to be reviewed in monthly QAPI meeting and review of any adverse findings</p> <p>Review of facility policy, Falls - Clinical Protocol, rev. 12/2024 revealed: Cause identification . for an individual who has fallen, staff will attempt to define possible causes . Treatment/Management . Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling . Monitoring and Follow-up . the staff and physician will monitor and document the individual's response to interventions intended to reduce falling and the consequences of falling . If interventions have been successful in preventing falling, the staff will continue with current approaches .</p> <p>A Past Non-Compliance Immediate Jeopardy (PNC IJ) was identified and presented to the Administrator and DON on 03/10/2025 at 3:30 PM. The noncompliance began on 01/26/2025 and ended on 02/02/2025. The facility corrected the noncompliance before the investigation began.</p>		