| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676448 | A. Building<br>B. Wing | 06/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Reserve at Richardson | 1610 Richardson Dr<br>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 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for three (Residents #1, #2, and #3) of ten residents reviewed for Reasonable Accommodation of Needs.<br><br>The facility failed to ensure the call light systems in Residents #1, #2, and #3's rooms were in a position that was accessible to the resident on 06/18/2025.<br><br>This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.<br><br>Findings included:<br><br>Resident #1<br><br>Record review of Resident #1's Face Sheet, dated 06/18/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness and lack of coordination.<br><br>Record review of Resident #1's Quarterly MDS (assessment used to determine functional capabilities and health needs) Assessment, dated 05/27/2025, reflected the resident had a severe impairment (requires significant assistance and support in daily life) in cognition with a BIMS (screening tool used to assess cognitive status) score of 07. The Quarterly MDS Assessment indicated the resident was dependent on staff for personal hygiene, transfer, and bed mobility.<br><br>Record review of Resident #1's Comprehensive Care Plan, dated 05/22/2025, reflected the resident was at risk for falls and one of the interventions was to be sure the resident's call light was within reach.<br><br>Observation and interview on 06/18/2025 at 8:56 AM revealed Resident #1 was in her bed, awake. It was observed that the resident's call light was hanging on the railing of the top portion of the bed. She said she seldom used the call light and she usually saw it at the side of her bed. The resident searched for her call light and said she could not find it.<br><br>Resident #2<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #2's Face Sheet, dated 06/18/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness and lack of coordination.<br><br>Record review of Resident #2's Quarterly MDS Assessment, dated 05/27/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Quarterly MDS Assessment indicated the resident required substantial assistance for toileting, shower, and dressing.<br><br>Record review of Resident #2's Comprehensive Care Plan, dated 05/26/2025, reflected the resident was at risk for falls and one of the interventions was to be sure the resident's call light was within reach.<br><br>Observation and interview on 06/18/2025 at 9:06 AM revealed Resident #2 was in her bed, awake. It was noted that her call light was on the floor. When asked where her call light was, the resident shrugged her shoulders.<br><br>Observation and interview on 06/18/2025 at 9:10 AM, revealed CNA C stated call lights should be with the residents at all times so they could call the staff if they needed to. She said she did not notice that Resident #1 and #2's call lights were not with them when she last checked the said residents. She went inside Resident #1's room and saw the call light was hanging on the railing of the bed and was not within the reach of the resident. She took the call light from the railing and placed it somewhere Resident #1 could reach it. She then went to Resident #2's room and saw the resident's call light was on the floor and even the cord of the call light could not be reached by the resident. She took the call light from the floor and placed it somewhere the resident could reach it. She said staff should make sure the call lights were within reach of the residents before they leave the room so that the needs of the residents could be addressed and also to prevent falls.<br><br>In an interview on 06/18/2025 at 9:17 AM, LVN F stated the call lights should be with the residents at all times in cases like the residents needing assistance or needing something from the nurse. He said he did not notice the call lights were not with Residents #1 and #2 when he did his round. He said the risk of the residents not having their call lights could be falls and frustrations.<br><br>Resident #3<br><br>Record review of Resident #3's Face Sheet, dated 06/18/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness and lack of coordination.<br><br>Record review of Resident #3's Quarterly MDS Assessment, dated 06/06/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 03. The Quarterly MDS Assessment indicated the resident required assistance for transfer and walking.<br><br>Record review of Resident #3's Comprehensive Care Plan, dated 05/09/2025, reflected the resident was at risk for falls and one of the interventions was to be sure the resident's call light was within reach. The Comprehensive Care Plan did not indicate that the resident was refusing to have his call light on his side.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation and interview on 06/18/2025 at 9:47 AM revealed Resident #3 was in his bed, awake. It was observed that his call light was on the floor behind the side table. When asked where was his call light, the resident did not answer.<br><br>Observation and interview on 06/18/2025 at 9:50 AM, revealed ADON B stated the call lights were important and should always be with the residents in case they needed assistance or help. She said whenever a staff was done with their treatment or care, they needed to make sure the call lights were with the residents before leaving the room. She said the call lights were for all residents, dependent or independent, and all the staff were responsible in making sure the call lights were with the residents. She said she would do an in-service about call light placement.<br><br>In an interview on 06/18/2025 at 1:28 PM, ADON A stated call lights were used by the residents to call the staff. Some residents were bed bound and could not get up to call the staff. She said, even for the residents that could get up, the call lights should still be with them because they might be having medical issues and nobody would know. ADON A said all the staff and managers were responsible for the call lights. She said the expectation was for the staff to scan the residents' rooms when they did their rounds and ensure the call lights were within reach of the residents before they leave the room. She said she would initiate an in-service regarding call light placement.<br><br>In an interview on 06/18/2025 at 1:32 PM, the Administrator stated the call lights were used by the residents to communicate their needs to the staff. He said the expectation was for the staff to make sure the call lights were with the residents before leaving their rooms. He said they would re-educate the staff about call light placements.<br><br>Record review of the facility's policy Answering the Call Light revised December 2024 revealed Purpose: The purpose of this procedure is to respond to the resident's requests and needs . General Guidelines . 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**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, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 (Resident #6) of one residents reviewed for Respiratory Care.<br><br>The facility failed to ensure Resident #6's breathing mask for his nebulizer (a medical device that turns liquid medicine into mist that could be inhaled through a face mask) was properly stored when not in use on 06/18/2025.<br><br>This failure could place residents at risk for respiratory infection and not having their respiratory needs met.<br><br>Findings include:<br><br>Record review of Resident #6's Face Sheet, dated 06/18/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with asthma (lung disorder caused by narrowing of the airways) and shortness of breath.<br><br>Record review of Resident #6's Comprehensive MDS Assessment, dated 06/05/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 05. The Comprehensive MDS Assessment indicated that the resident had asthma.<br><br>Record review of Resident #6's Comprehensive Care Plan, dated 06/18/2025, reflected the resident had an ineffective gas exchange (disruption of the oxygen and carbon dioxide exchange in the lungs) and one of the interventions was to administer medications and respiratory treatments as ordered.<br><br>Record review of Resident #6's Physician Order, dated 01/07/2025, reflected Ipratropium-Albuterol Solution 0.5 - 2.5 (3) mg/3 mL 3 ml inhale orally every 4 hours as needed for SOB or wheezing via nebulizer.<br><br>Observation and interview on 06/18/2025 at 9:29 AM revealed Resident #6 was in her bed, awake. A nebulizer machine was noted on the resident's side table with a breathing mask connected to it. The breathing mask was not bagged. She said the nurse would put it on and took it off after the breathing treatment was done. She said it was also the nurse who would put it in the drawer. She said she was not aware where the nurse put it after taking it off.<br><br>In an interview on 06/18/2025 at 9:32 AM, LVN G stated the order for Resident #6's breathing treatment was as needed. She said as needed or daily, the breathing mask should be bagged and kept clean to prevent respiratory infection and other respiratory issues. She said she did not notice the unbagged breathing mask when she did her rounds. it was observed that LVN G disconnected the breathing mask and said she would change it.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 06/18/2025 at 1:34 PM, ADON B stated the breathing mask was supposed to be in a bag when the resident was not using it to prevent cross contamination and worsening of any respiratory issues. She said the expectation was for the staff to be mindful and make sure the breathing mask was bagged after administering the breathing treatment. She said it did not matter if the order was daily or as needed, the breathing mask must be in a plastic bag to keep it clean. She said she would conduct an in-service about respiratory care specifically about bagging the breathing mask.<br><br>In an interview on 06/18/2025 at 1:32 PM, the Administrator stated the breathing mask should be stored properly to prevent development of respiratory issues. He said they would re-educate the staff regarding proper storage of the breathing masks.<br><br>Record review of the facility's policy, Departmental (Respiratory Therapy) -Prevention of Infection reviewed December 2024 revealed Purpose: The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment . Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol . 7. Store the circuit in plastic bag. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that drugs and biologicals were stored in locked compartments for two (Resident #4 and Resident #5) of two residents reviewed for Storage of Drugs and Biologicals.<br><br>The facility failed to ensure that no medications were inside Resident #4 and Resident #5's room.<br><br>This failure could place the residents at risk of overdose or misuse of medications.<br><br>Findings included:<br><br>Resident #4<br><br>Record review of Resident #4's Face Sheet, dated 06/18/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with nasal congestion, rashes, and bipolar disorder (a mental health condition that causes extreme mood swings between emotional highs and lows).<br><br>Record review of Resident #4's Comprehensive MDS Assessment, dated 05/06/2025, reflected the resident was cognitively intact (capable of normal cognition and needs little support) with a BIMS score of 15. The Comprehensive MDS Assessment indicated that the resident had asthma and bipolar disorder.<br><br>Record review of Resident #4's Comprehensive Care Plan, dated 06/18/2025, reflected the resident had an ineffective gas exchange (disruption of the oxygen and carbon dioxide exchange in the lungs) and one of the interventions was to administer medications and respiratory treatments as ordered. The Comprehensive Care Plan did not indicate that the resident could self-administer her medications.<br><br>Record review of Resident #4's Physician Order on 06/18/2025 reflected the resident did not have an order for nasal spray.<br><br>Record review of Resident #4's Physician Order, dated 05/13/2025, reflected Nystatin Powder . Apply 1 application transdermal two times a day for redness.<br><br>Record review of Resident #4's Assessment on 06/18/2025, reflected no assessment for self-administration of medications.<br><br>Observation and interview on 06/18/2025 at 9:13 AM revealed Resident #4 was in her bed, awake. It was noted that there was a container of nasal spray and a small cup with powder on her side table. She said she would do her nasal sprays and would apply the powder on herself. When asked what the powder on the cup was for, the resident said the powder was for her redness on her lower abdomen .<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation and interview on 06/18/2025 at 9:17 AM, revealed LVN F stated he did not notice that there was a nasal spray on Resident #4's side table. He said the powder was for her rashes. He said, since the powder was a treatment, the nurses were supposed to administer the powder. He said there should be no medication in the resident's room because of the danger of adverse reactions such as allergy and overdose. He said he would go the resident's room and would talk to the resident.<br><br>Observation and interview on 06/18/2025 at 9:21 AM revealed ADON A was holding Resident #4's nasal spray and said she talked with the resident regarding the medication left inside the room. She said there should be an assessment in place that the resident could self-administer her medications as well as a care plan about it. She said she also needed a physician order for the nasal spray. She said no medications should be inside the room because the resident might accidentally consume more than needed and overdose. She said she would check the other rooms if there were medications inside the rooms. She said she would do an in-service about checking if there were medications inside the room and not leaving medications inside the room.<br><br>Resident #5<br><br>Record review of Resident #5's Face Sheet, dated 06/18/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with allergic rhinitis (an allergic reaction to tiny particles in the air called allergens), rashes, and depression (persistent feeling of sadness or loss of interest).<br><br>Record review of Resident #5's Comprehensive MDS Assessment, dated 05/29/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated that the resident had depression.<br><br>Record review of Resident #5's Comprehensive Care Plan, dated 03/14/2025, reflected the resident used antidepressant medication and one of the interventions was to educate the resident about risks, benefits and the side effects and/or toxic symptoms of medication. The Comprehensive Care Plan did not indicate that the resident could self-medicate.<br><br>Record review of Resident #5's Physician Order on 06/18/2025 reflected the resident did not have an order for eye drops.<br><br>Record review of Resident #5' Physician Order, dated 09/26/2024, reflected Cleanse peri area and apply barrier cream and antifungal powder q shift and prn.<br><br>Record review of Resident #5's Assessment on 06/18/2025, reflected no assessment for self-administration of medications.<br><br>Observation on 06/18/2025 at 9:22 AM revealed Resident #5 was in her bed, awake. It was noted that there were Systane eyedrops and antifungal powder at her bedside table.<br><br>In an interview on 06/18/2025 at 9:35 AM, Resident #5 said she had been using the Systane for her dry eyes. She said she did not know if the facility knew about it but it had always been in her bedside table. She said the staff would apply the power on her bottom after the staff clean and change her.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 06/18/2025 at 12:33 PM, LVN G said she did not notice that Resident #5 had Systane and antifungal powder at her bedside table. She said she would check it as soon as the interview was over. She said it should not be on the resident's bedside table because the resident might accidentally drink it or a confused resident might take it use it differently.<br><br>In an interview on 06/18/2025 at 1:34 PM, ADON B stated there should be no medications inside the residents' rooms because accidental consumption might cause adverse reactions such as allergic reactions and overdose. She said she would check the rooms if there were any medications that the residents were using to self-medicate. She said she would talk to Resident #5 to see if she needed the eyedrops and get an order for it. She said there should also be an assessment that the resident was capable of doing the eyedrops by herself.<br><br>In an interview on 06/18/2025 at 1:32 PM, the Administrator stated the expectation was no medications would be inside the residents' rooms to prevent any untoward incidents like overdose and allergic reactions. He said they would re-educate the staff to check the residents' rooms if there were medications inside and if there were, make sure the residents were capable of self-administration.<br><br>Record review of facility policy, Storage of Medications 2001 Med-Pass, Inc. revised April 2021 revealed : Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner . Policy Interpretation and Implementation . 6. Antiseptics, disinfectants, and germicides used in any aspect of resident care . shall be stored separately from regular medications. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**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 one (Resident #5) of 1 resident reviewed for Infection Control.<br><br>The facility failed to ensure CNA D performed hand hygiene and changed her gloves while providing incontinent care to Resident #5 on 06/18/2025.<br><br>This failure could place residents at risk of cross-contamination and development of infections.<br><br>Findings included:<br><br>Record review of Resident #5's Face Sheet, dated 06/18/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with diarrhea (loose bowel movement).<br><br>Record review of Resident #5's Comprehensive MDS Assessment, dated 05/29/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated that the resident was incontinent for bowel and bladder.<br><br>Record review of Resident #5's Comprehensive Care Plan, dated 03/14/2025, reflected the resident had an ADL self-care performance deficit and one of the interventions was the resident required assistance for toilet use.<br><br>Observation on 06/18/2025 at 9:22 AM revealed CNA D and CNA E were about to do incontinent care for Resident #5. Both CNAs washed their hands and put on pairs of gloves. CNA D positioned herself to the left side of the resident while CNA E was on the right side. CNA D unfastened the resident's brief and pushed it between the resident's legs. CNA E cleaned the resident's perineal area (area between the legs). In the process of incontinent care, CNA E ran out of gloves and CNA D said she would get her some from the box of gloves placed on the overhead table of the resident. CNA D removed her gloves and pulled some gloves from the box. CNA D did not sanitize her hand before touching the new gloves. After cleaning the perineal area, both CNAs assisted the resident to her left side and CNA E continued to clean the resident's bottom. After cleaning the resident's bottom, she took off her gloves, sanitized her hands, and put on a new pair of gloves. Both CNAs assisted the resident to roll to her right side and CNA D proceeded to clean the other side of the resident's bottom. After cleaning the resident's bottom, she pulled the soiled brief, and she asked CNA E to hand her over the brief that was placed on the resident's overbed table. CNA E took the new brief from the overhead table and handed it to CNA D. CNA D did not change her gloves after cleaning the resident's bottom and before touching the new brief. CNA D put the brief under the resident and fixed it. After fixing the brief, both CNAs took off their gloves and washed their hands.<br><br>In an interview on 06/18/2025 at 9:35 AM, CNA D stated she should have changed her gloves after cleaning the resident's bottom and before touching the new brief because her gloves were already soiled. She said not changing her gloves could cause transfer of germs from her soiled gloves to the new brief. She said she should sanitize her hands as well before putting on a new pair of gloves. She said she would be mindful to change her gloves after touching something dirty and do hand hygiene.<br><br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 06/18/2025 at 9:40 AM, CNA E stated they were doing good until the gloves were not changed after CNA D did not change her gloves after cleaning the resident's bottom. She said she should have reminded CNA D to change her gloves and sanitize her hands before handing her the new brief. She said touching the new brief with soiled gloves could also cause urinary tract infections.<br><br>In an interview on 06/18/2025 at 1:34 PM, ADON B stated CNA D and CNA E made her aware of the failure during incontinent care. She said she reminded both CNAs to change their gloves after touching something dirty or presumed dirty to prevent cross contamination and urinary tract infection. She said she also reminded CNA D to do hand hygiene after taking off the gloves. She said the expectation was for the staff to change their gloves when going from dirty to clean and to do hand hygiene in between changing of gloves. She said she would do a one-on-one in-service with both CNAs and then would also do an in-service for all the staff providing direct care.<br><br>In an interview on 06/18/2025 at 1:32 PM, the Administrator stated not changing the gloves when going from soiled to clean and not sanitizing in between changing of gloves could contribute to cross contamination and infection. He said the expectation was for the staff to follow the policy and procedures pertaining to infection control and hand hygiene. He said they would re-educate the staff about infection control and the importance of hand hygiene.<br><br>Record review of the facility's policy, Hand-Washing/Hand Hygiene reviewed December 2024 revealed Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections . Policy Interpretation and Implementation . 7. Use an alcohol-based hand rub . f. Before donning sterile gloves . j. After contact with blood or bodily fluids . m. After removing gloves . Applying and Removing Gloves . l. Perform hand hygiene before applying non-sterile gloves.<br><br>Record review of the facility's policy Infection Control Guidelines for All Nursing Procedures reviewed December 2024 revealed Purpose: To provide guidelines for general infection control while caring for residents . 4. Employees must wash their hands . d. After removing gloves . 5. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub . b.<br><br>Before donning sterile gloves . j. After removing gloves. |