

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 12/02/2025
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)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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 one (Resident #1's) of ten residents reviewed for privacy and confidentiality. The facility failed to ensure ADON A did not leave Residents #1's medical information exposed and unattended on top of the nurse's station countertop on 12/02/2025. This failure could place the residents at risk of their medical information being accessed by unauthorized individuals. Findings included: Record review of Resident #1's Face Sheet, dated 12/02/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with depression (persistent feeling of sadness or loss of interest). Record review of Resident #1's Comprehensive MDS (assessment used to determine functional capabilities and health needs) Assessment, dated 11/30/2025, reflected the resident was unable to complete the interview to determine the BIMS (screening tool used to assess cognitive status) score. The MDS indicated the resident had depression. Record review of Resident #1's Comprehensive Care Plan, dated 04/28/2025, reflected the resident had depression and one of the interventions was to administer medications as ordered. Record review of Resident #1's Physician's Order, dated 11/26/2025, reflected Quetiapine Fumarate Oral Tablet 150 MG Verbal Active (Quetiapine Fumarate) Give 1 tablet by mouth at bedtime for DEPRESSION. An observation on 12/02/2025 at 10:07 AM, revealed an untitled piece of paper was left on top of a nurse's station countertop. On the piece of paper was Resident #1's name, medical record number, her Physician's name, the proposed course of therapy, the name of the medication, and condition being treated. As per the paper, the condition being was a psychotic behavior. The paper was left unattended, facing the hallway, and nobody was in the nurse's station. During an observation and interview on 12/02/2025 at 10:10 AM, ADON A stated she was the one who left the piece of paper on top of the nurse's station countertop. She took the paper and dropped it inside the nurse's station. She said she should have flipped it or put it inside the nurse's station because Resident #1's medical information was exposed and could be seen by anybody that would go to the nurse's station. She said the resident's medical information was restricted to unauthorized individuals and it was a HIPAA violation if the information was visible to others that was not providing care to the residents. During an observation and interview on 12/02/2025 at 10:59 AM revealed Resident #1 was in her bed, awake. The resident did not reply when asked if she felt down lately. In an interview on 12/02/2025 at 11:50 AM, the DON stated personal and medical information about a resident should not be exposed for everybody to see because they were confidential. She said the health information of a resident should be protected and could not be shared without the permission of the resident or the resident's responsible party. She said the staff was expected to provide full privacy and confidentiality of information for all residents. The DON stated she would start an in-service about privacy and confidentiality of the residents' information. In an interview on 12/02/2025 at 1:28 PM, the Administrator stated the expectation was the staff to make sure the residents' personal and medical information was not exposed and protected because it was a violation of the residents' privacy and confidentiality. He said he would collaborate with the DON to do an in-service about privacy and confidentiality. Record review of the facility's policy titled Resident Rights dated December 2024 reflected Policy Interpretation and Implementation . These rights include the resident right's right to . t. privacy and confidentiality. Record review of the facility's policy titled Protected Health Information (PHI), Management and Protection of dated December 2023 reflected Policy Statement . Protected Health Information (PHI) shall not be used or disclosed . Policy Interpretation and Implementation . 1. It is the responsibility of all personnel who have access to resident and facility information to ensure that such information is managed and protected to prevent unauthorized release or disclosure.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on observations, interviews, and record review, the facility failed to store all drugs and biologicals in a locked cart or under direct observation of authorized staff in an area where residents could access it for one (Nurse Cart) of one cart reviewed for medication storage. The facility failed to ensure that LVN B locked the nurse cart before leaving it unattended on 12/02/2025. This failure could place the residents at risk of accessing/opening the cart causing accidental overdose, adverse reactions, or misuse of medications. Findings included: Observation on 12/02/2025 at 10:04 AM, revealed a nurse medication cart was parked outside the nurse's station unlocked. The cart and the drawers were facing the hallway, the drawers contained medications. It was observed that a resident in a wheelchair was sitting approximately ten steps from the open cart. During an observation and interview on 12/02/2025 at 10:06 AM, MA C saw the cart and locked it. She said the cart was used by the nurses, but she was not sure who was currently using it. She said the cart should always be locked when not in use because residents, staff, and visitors might open it and get some medications from the cart. MA C said residents, confused or not, might consume the medications causing allergies or overdose. In an interview on 12/02/2025 at 10:10 AM, ADON A stated the carts should be locked every time they were left unattended. She said the staff should lock the carts before leaving them to prevent unauthorized individuals from opening them. She said confused residents might open the cart and ingest something to which they were allergic. She said the expectations was the staff using the carts would lock the cart after using them or leaving them unattended. She said she would find out who was using the cart so she could talk to the staff and remind him or her to always lock the cart. She said she would coordinate with the DON to do an in-service about the importance of the locking the carts. In an interview on 12/02/2025 at 11:50 AM, the DON stated she was made aware about a cart left unlocked. She said the staff should be mindful to lock their carts everytime they would step away from their carts. She said resident, staff, or even visitors might open the drawers and got hold of the medications inside. She said adverse reactions could result such as allergic reactions or even overdose. She said she would do an in-service about locking the carts every time the staff would leave their carts. She said she did not even know how long the cart was left unlocked. She said the expectation was for the staff to lock the carts when left unattended. In an interview on 12/02/2025 at 1:28 PM, the Administrator stated the expectation was for all the carts, nurses' carts, medication aide carts, and the wound care carts, would always be locked to protect the residents from getting any medications that they might be allergic to. She said she would collaborate with the DON to do an in-service pertaining to locking the carts. In an interview on 12/03/2025 at 3:01 PM, LVN B stated he left his cart to go to the restroom. He said he should have made sure his cart was locked before leaving it so that nobody could open it. He said a resident might consume the medications that could lead to hypotension, hypoglycemia, allergic reactions, or even overdose. LVN B said he would be mindful to keep his cart locked when he was not using it. Record review of the facility's policy titled Storage of Medications dated December 2024 reflected Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner . Policy Interpretation and Implementation . 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.</p>		