STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to treat each resident with respect, dignity, and care in a manner and environment that promoted maintenance or enhancement of his or her quality of life for one (Resident #58) of nineteen residents reviewed for Dignity. The facility failed to ensure CNA C pulled the privacy bag all the way down on Resident #58's catheter bag (collects urine from the urinary bladder) so the catheter bag and its content would not be visible during lunchtime on 03/11/2025. This failure could place the residents at risk of not having their right to a dignified existence maintained. Findings included: Record review of Resident #58's Face Sheet, dated 03/11/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with obstructive and reflux uropathy (a blockage in the urinary tract). Record review of Resident #58's Quarterly MDS Assessment, dated 01/27/2025, reflected the resident had a moderate impairment in cognition with a BIMS score of 10 (resident may need additional support and monitoring). The Quarterly 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 bag). Record review of Resident #58's Care Plan, dated 01/27/2025, reflected the resident had resident rights and one of the interventions was to be treated with dignity and respect. Observation on 03/11/2025 at 12:13 PM revealed Resident #58 was in the dining area eating lunch. It was observed that the resident had a catheter hanging at the lower back of the resident's wheelchair. The catheter bag and its content were visible to other individuals in the dining area. It was observed that there was a privacy bag on top of the catheter bag but was not pulled down to cover the entirety of the catheter bag. (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
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with ADON A on 03/11/2025 at 12:17 PM revealed ADON A saw Resident #58's catheter bag was not inside the privacy bag. She pulled the privacy bag downward to fully cover the catheter bag. She said whoever transferred Resident #58 should have made sure that the catheter bag was inside a privacy bag or was fully covered to provide dignity to the resident. She said she would find out who transferred the resident so she could remind and re-educate the staff to make sure the catheter bag was inside a privacy bag. In an interview on 03/12/2025 at 11:38 AM, CNA C stated she transferred Resident #58 to her wheelchair for lunch the day before. She said she placed the catheter bag with its privacy bag at the back of the wheelchair. She said she thought she pulled the privacy bag on the catheter bag. She said she did not notice that the catheter bag and its content could still be seen. She said she would make sure next time to fix the privacy bag before going out of the room. She said the ADON A told her what she did and did a one-on-one in-service with her about dignity and making sure the catheter bag was fully covered. In an interview on 03/12/2025 at 12:36 PM, the DON stated the catheter bag, and its content should not be visible to others. She said the privacy bag should have been placed properly inside of the privacy bag should have been pulled down all throughout. She said the expectation was for the staff to be mindful when they bring the resident with catheter outside their room. She said she would do an in-service about dignity and making sure the catheter bag was inside a privacy bag. In an interview on 03/12/2025 at 1:13 PM, the Administrator stated his expectation was the catheter bag was covered to provide dignity. He said he would coordinate with the DON on how to go forward about the issue. Record review of facility policy Quality of Life - Dignity reviewed December 2024 revealed Policy Statement: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality . Policy Interpretation and Implementation . Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by . a. Helping the resident to keep urinary catheter bags covered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 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** 47743 Based on interviews and record reviews, 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 attain or maintain the resident's highest practicable mental and psychosocial well-being for 3 of 8 residents (Resident #2, #74, and #182) reviewed for Care Plans. 1. The facility failed to ensure Resident #2 was care planned for oxygen administration. 2. The facility failed to ensure Resident #74 was care planned for condom catheter and hospice care. 3. The facility failed to ensure Resident #182 was care planned to use the call light to alert staff. These failures could place residents at risk of not receiving the necessary care and services needed. Findings include: 1. Record review of Resident #2's Face Sheet, dated 03/11/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with emphysema (a lung disease that damages the air sacs in the lung causing shortness of breath) and respiratory failure with hypoxia (insufficient amount of oxygen in the body). Record review of Resident #2's Quarterly MDS Assessment, dated 02/14/2025, reflected the resident was cognitively intact with a BIMS score of 13 (resident capable of normal cognition and needs little support). The Quarterly MDS Assessment indicated that the resident was on oxygen therapy while a resident of the facility. Record review of Resident #2's Comprehensive Care Plan on 02/14/2025 reflected no care plan for oxygen therapy. Record review of Resident #2's Physician Order on 03/11/2024 reflected no order for oxygen therapy. Record review of Resident #2 Vital Signs - Oxygen saturation on 03/11/2025 reflected the resident was on oxygen via nasal cannula. Observation on 03/11/2025 at 9:32 AM revealed Resident #2 in her bed, awake. It was observed that the resident was using oxygen via nasal cannula. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with Resident #2 on 03/11/2025 at 10:34 AM revealed the resident was still in her bed and was still using oxygen via nasal cannula at 3 liters per minute. Resident #2 stated she had been using oxygen for months and was almost using it every day. She said it won't hurt to have an extra air. 2. Record review of Resident #74's Face Sheet, dated 03/11/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with unstageable pressure ulcer to the sacrum (unable to identify the depth of the pressure ulcer) and AIDS (acquired immunodeficiency syndrome: the immune system was severely damaged). Record review of Resident #74's Quarterly MDS Assessment, dated 01/26/2025, reflected the resident was cognitively intact with a BIMS score of 13 (resident capable of normal cognition and needs little support). The Quarterly MDS Assessment indicated that the resident was using an external catheter and was receiving hospice care. Record review of Resident #74's Comprehensive Care Plan on 01/26/2025 reflected no care plan for external catheter and hospice care. Record review of Resident #74's Physician Order on 03/11/2024 reflected no order for condom catheter. Record review of Resident #74's Physician Order, dated 01/17/2024, reflected Resident has been admitted to Hospice Services. Record review of Resident #74's Bowel and Bladder Program Screener, dated 01/07/2025, reflected the resident used a catheter. Observation on 03/11/2025 at 9:42 AM revealed Resident #74 was in his bed, awake. It was observed that the resident had a catheter bag hanging at the side of the bed. Observation and interview with Resident #74 on 03/11/2025 at 1:54 AM revealed the resident was still in his bed with a catheter bag at the side of the bed. The resident stated he had been with a catheter for a while. He said if he was not mistaken, he had a catheter since January. In an interview on 03/11/2025 at 11:46 AM, LVN D stated Resident #74 had a pressure ulcer to his sacrum that was present during his admission. She said the resident had a condom catheter (Male external catheter) to facilitate healing of the wound because the resident would sometimes refused care and repositioning. She said the resident was also admitted to hospice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 03/12/2025 beginning at 7:53 AM, ADON A stated she was responsible for doing some of the residents' care plan. She said care plans were done to make sure the residents' needs and services were provided. She said residents must have care plans to fully provide the care they needed. She said without the care plan, the staff would not be synched on the care of the residents and their needs would not be addressed. She said if a resident was using oxygen, there should be a care plan for oxygen use. She said if a resident was using a catheter, regardless of the type of catheter, there should be a care plan for catheter. ADON A logged on to her computer and went to Resident #2's care plan. She said Resident #2 was using oxygen and there should be care plan for oxygen. ADON A started doing Resident #2's care plan for oxygen therapy. ADON A then went to Resident #74's room and saw the Resident #74 had a catheter bag hanging at the side of the bed. She said Resident #74 used a condom catheter. ADON A went back to her computer and saw Resident #74 did not have a care plan for catheter. ADON did a care plan for Resident #74's catheter. She said she thought she did a care plan for Resident #74's catheter. She said she was not sure if a resident admitted on hospice needed a care plan for hospice. She said the expectation was for the residents to be care planned accordingly. She said it was an oversight on her part. She said she would coordinate with MDS Nurse and would make an audit of the resident's care plan. In an interview on 03/12/2025 at 11:22 AM, the MDS Nurse stated she was made aware by ADON A about the issues in care plans. She said she was responsible in doing the care plans. She said care plans were important because they reflects the care needed by the residents She said she would audit the care plans of the residents. She said without the care plans, the staff would not know the latest goals and interventions for the residents and the needs of the resident would not be met. She said if a resident was admitted to hospice, there should be a care plan for hospice. In an interview on 03/12/2025 at 12:36 PM, the DON stated every resident needed a comprehensive care plan to ensure the residents received the care appropriate to their needs. She said the care plan should be in place so the staff providing care would be on the same page. She added, without the care plan, there could be confusion with the care of the residents. The DON said the care plan should reflect the resident's problem lists, the goals, and the interventions. She said the care plan should be done every quarter to monitor if there were interventions that needed to be changed or the goals were not being met. She said the expectation was every resident had a care plan. She said she would coordinate with the MDS Nurse and the ADONs to audit to the care plans of the residents. In an interview on 03/12/2025 at 1:13 PM, the Administrator stated all the residents should be care planned accordingly to make sure all the care needed were provided. He said without the care plan, the staff would not know and understand what kind of care to provide. The Administrator concluded that the expectation was for the staff to ensure that the residents' care plan were complete and individualized. He said he would coordinate with the DON to make sure that the staff responsible in making the care plans would be conscious enough to do the care plans. 3. Record review of Resident #182's face sheet, dated 03/11/25, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #182 was diagnosed with Alzheimer's disease (severe memory loss), quadriplegia (loss of functions of limbs), and contracture (shortening of muscles). Record review of Resident #182's Quarterly MDS Assessment, dated 01/10/25, reflected the resident had a BIMS score of 08 (moderate impairment). For ADL care it reflected for transfers, toileting, and bathing and the resident was totally dependent for assistance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #182's Comprehensive Care Plan, dated 02/05/25, did not reflect an intervention for the resident's inability use the call light button. In an interview on 03/12/25 at 12:00 PM, the DON was advised Resident #182 was unable to use his call light for assistance because of his physical and mental decline. She stated both hands were contracted, and his cognitive decline impacted his ability to use the equipment. She stated the resident should have been care planned for staff to conduct more frequent rounds with residents that were nonverbal and unable to use the call light to alert staff of any emergencies. She stated the risk of his inability to use the call light being care planned, could result in staff not making more frequent checks on the resident and an emergency concern going undetected. Record review of facility's policy, Comprehensive Care Planning (12/2024) revealed Our facility's Care Planning/interdisciplinary Team is responsible for the development of an individual comprehensive care plan for each resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on interviews and record reviews, the facility failed to ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team for one of (Resident #19) eight residents reviewed for Revised Care Plans. The facility failed to complete a quarterly care plan for Resident #19. These failures placed residents at risk of needs not being met. Findings included: Record review of Resident #19's Face Sheet, dated 03/11/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with obstructive sleep apnea (a sleep disorder where breathing is interrupted repeatedly during sleep). Record review of Resident #19's Quarterly MDS Assessment, dated 01/30/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 01 (resident required significant assistance and support in daily life). The Quarterly MDS Assessment indicated that the resident was on non-invasive mechanical ventilator (respiratory support such as CPAP). Record review of Resident #19's Comprehensive Care Plan on 03/11/2025 reflected the last quarterly care plan completed for the resident was 06/12/2024. Record review of resident #19's Comprehensive Care Plan, dated 06/12/2024, reflected the resident had breathing difficulty related to sleep apnea and one of the interventions was the resident to wear CPAP (continuous positive airway pressure: machine used to deliver pressurized air through a mask to keep airways open) every night. Record review of Resident #19's Physician Order, dated 10/26/2023, reflected APPLY auto CPAP 18 &7 every evening and night shift. Observation on 03/11/2025 at 9:38 AM revealed Resident #19 was not inside the room. It was observed that the resident had a CPAP machine on her right side table with a CPAP mask was attached to it. In an interview on 03/11/2025 at 9:47AM, LVN D stated Resident #19 used CPAP at night because the resident had a diagnosis of sleep apnea. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on03/12/2025 at 11:17 AM, ADON A stated the care plan was supposed to be done quarterly and said the MDS Nurse was already updating Resident #19's care plan. She said care plans were done quarterly to ensure the needs of the residents were met and addressed. She said if the care plan were not reviewed, it showed as if the residents were not being assessed. She said the expectation was for the care plans be done accordingly and timely. She said it was an oversight on her part. She said the MDS Nurse and herself were responsible in auditing the care plans. She said she would coordinate with MDS Nurse and would make an audit of the residents care plan. In an interview on 03/12/2025 at 11:22 AM, the MDS Nurse stated she was made aware by ADON A about the issues in care plans. She said she was currently updating Resident #19's care plan. She said care plans were supposed to be done quarterly to reflect that the residents were being assessed accordingly. She said she would audit the care plans of the residents. She said without the care plans, the staff would not know the latest goals and interventions for the residents. In an interview on 03/12/2025 at 12:36 PM, the DON stated every resident needed a comprehensive care plan to ensure the residents received the care appropriate to their needs. She said the care plan should be in place so the staff providing care would be on the same page. She added, without the care plan, there could be confusion with the care of the residents. She said the care plan should be done every quarter to monitor if there were interventions that needed to be changed or the goals were not being met. She said the expectation was every resident had a care plan and care plans should be completed quarterly or if the resident had a change in condition. She said she would coordinate with the MDS Nurse and the ADONs to audit to the care plans of the residents. She said a schedule for the residents' care plans was being done and updated so that the resident would be care planned on time. In an interview on 03/12/2025 at 1:13 PM, the Administrator stated all the residents should be care planned accordingly and timely to make sure all the care needed were provided. He said without the care plan, the staff would not know and understand what kind of care to provide. The Administrator concluded that the expectation was for the staff to ensure that the residents' care plan were complete and individualized. He said he would coordinate with the DON to make sure that the staff responsible in making the care plans would be conscious enough to do the care plans. Record review of facility's policy, Comprehensive Care Planning (12/2024) revealed Our facility's Care Planning/interdisciplinary Team is responsible for the development of an individual comprehensive care plan for each resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45055 Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of accident hazards as was possible for 1of 6 residents (Resident #25) reviewed for accident prevention. The facility failed to ensure resident #25 had physician orders for the bolster pads that were applied to her mattress for fall prevention. This failure could prevent the resident from having an environment that was free and clear of accidents and hazards. Findings include: Record review of Resident #25's Face Sheet, dated 03/11/25, reflected she was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included unsteadiness on feet, dementia (cognitive decline), and history of falling. Record review of Resident #25's Quarterly Minimum Data Set (MDS) assessment, dated 02/28/25, reflected she had a BIMS score of 00 (severe cognitive impairment). For ADL care it reflected for transfers, toileting, and bathing and the resident was totally dependent for assistance. Record review of Resident #25's Quarterly Care Plan, dated 01/28/25, reflected the resident had a history of falls and an intervention was to provide bolsters to the mattress. Record review of Resident #25's physician orders, dated 03/11/25, reflected no physician orders for the bolster pads. An Observation on 03/11/25 at 09:25 AM, revealed Resident #25 having bolster pads on her bed. In an interview on 03/11/25 at 09:30 AM, the DON was advised of Resident #25 having bolster pads on her bed, but no physician orders for the equipment was observed for the resident. The DON stated she thought the resident did have physician orders, but after checking the resident's records, she did not observe one. She stated the risk of the resident not having physician orders for the bolster pads could result in her getting injured if she attempted to get out of the bed. The facility's policy Restraints (02/24) reflected Restraints shall only be used for the safety and wellbeing of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptoms and never for discipline or staff convenience.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 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** 47743 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 (Resident #74) two residents reviewed for Catheter Care. The facility failed to ensure that Resident #74's external catheter (non-invasive to collect urine from the bladder such as a condom catheter) had an order on 03/11/2025. This failure could place residents at risk of needs for catheter care not met. Findings included: Record review of Resident #74's Face Sheet, dated 03/11/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with unstageable pressure ulcer to the sacrum (unable to determine the depth of the pressure ulcer). Record review of Resident #74's Quarterly MDS Assessment, dated 01/26/2025, reflected the resident was cognitively intact with a BIMS score of 13 (resident capable of normal cognition and needs little support). The Quarterly MDS Assessment indicated that the resident was using an external catheter . Record review of Resident #74's Comprehensive Care Plan on 01/26/2025 reflected no care plan for external catheter. Record review of Resident #74's Physician Order on 03/11/2024 reflected no order for condom catheter (external urinary catheter that are worn like a condom). Record review of Resident #74's Bowel and Bladder Program Screener, dated 01/07/2025, reflected the resident used a catheter. Observation on 03/11/2025 at 9:42 AM revealed Resident #74 was in his bed, awake. It was observed that the resident had a catheter bag hanging at the side of the bed. Observation and interview with Resident #74 on 03/11/2025 at 1:54 PM revealed the Resident #19 was still in his bed with a catheter bag at the side of the bed. The resident stated he had been with a catheter for a while. He said if he was not mistaken, he had a catheter since January. In an interview on 03/11/2025 at 11:46 AM, LVN D stated Resident #74 had a pressure ulcer to his sacrum that was present during his admission. She said the resident had a condom catheter to facilitate healing of the wound because the resident would sometimes refuse care and repositioning. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 03/12/2025 at 7:53 AM, ADON A stated if a resident had a catheter, there should be an order for catheter. ADON A went to Resident #74's room and saw Resident #74 had a catheter bag hanging at the side of the bed. She said Resident #74 used a condom catheter. ADON A went back to her computer and saw Resident #74 did not have an order for catheter. She said she would go ahead and make an order for the resident's catheter. She said the resident had a condom catheter to prevent contamination of the resident's pressure ulcer to his bottom. She said the expectation was for the staff to make sure a physician order was in place. She said she would coordinate with the DON for an in-service regarding making sure there was order for a catheter. In an interview on 03/12/2025 at 12:36 PM, the DON stated there should be an order for everything done for the residents, whether medications, treatment, diet, and therapy. She said if Resident #74 was using a condom catheter, an order for it should be in place. She said the physician orders served as a communication tool for the medical care that a resident needed. She said without an order, the staff caring for the resident would not know the needed interventions with regards to the resident's condom catheter. She said the expectation was for the staff to make sure there was an order for the condom catheter. She said she would conduct an in-service about the need for a physician order. In an interview on 03/12/2025 at 1:13 PM, the Administrator stated there should be orders for everything done for the residents. He said she would coordinate with the DON to educate and re-educate the nursing staff to make sure there was a physician order for everything done for the residents. In an interview on 03/13/2025 at 11:46 AM, CNA D stated she was made aware by ADON A that Resident #74 did not have an order for his condom catheter. She said she did not notice that there was no order for the resident's catheter. She said she knows what she should do when a resident had a catheter but there should still be an order for it. she said she would check the physician orders of other residents with catheter if there was a physician order for it. She said the resident had the condom catheter to facilitate healing of his pressure ulcers on his bottom. Record review of facility policy Medication and Treatment Orders 2001 Med-Pass, Inc. revised July 2016 revealed Policy Statement: Orders for medications and treatments will be consistent with principles of safe and effective order writing . Policy Interpretation and Implementation . 1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state . 9. Orders for medications must include a. Name and strength of the drug; b. Number of doses, start and stop date, and/or specific duration of therapy; c. Dosage and frequency of administration; d. Route of administration; e. Clinical condition or symptoms for which the medication is prescribed; and f. Any interim follow-up requirements.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 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** 47743 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 4 of 8 residents (Resident #2, #19, #39, and #67) reviewed for Respiratory Care. 1. The facility failed to ensure Resident #2 had an order for oxygen administration on 3/11/2025. 2. The facility failed to ensure Resident #19's mask for CPAP was stored properly on 3/11/2025. 3. The facility failed to ensure Resident #39's oxygen tubing was properly stored when not in use on 03/11/2025. 4. The facility failed to ensure Resident #67's CPAP mask, for the CPAP machine was placed in a sanitary bag to avoid contamination while not in use and had active physician orders for use of the CPAP machine. These failures could place residents at risk for respiratory infection and not having their respiratory needs met. Findings include: 1. Record review of Resident #2's Face Sheet, dated 03/11/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with emphysema (a lung disease that damages the air sacs in the lung causing shortness of breath) and respiratory failure with hypoxia (insufficient amount of oxygen in the body). Record review of Resident #2's Quarterly MDS Assessment, dated 02/14/2025, reflected the resident was cognitively intact with a BIMS score of 13 (resident is capable of normal cognition). The Quarterly MDS Assessment indicated that the resident was on oxygen therapy while a resident of the facility. Record review of Resident #2's Comprehensive Care Plan on 02/14/2025 reflected no care plan for oxygen therapy. Record review of Resident #2's Physician Order on 03/11/2024 reflected no order for oxygen therapy. Observation and interview with Resident #2 on 03/11/2025 at 10:34 AM revealed the resident was still in her bed and was still using oxygen via nasal cannula at 3 liters per minute. Resident #2 stated she had been using oxygen for months and was almost using it every day. She said it won't hurt to have an extra air. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/13/2025 at 11:46 AM, CNA D stated she was made aware by ADON A that Resident #2 did not have an order for her oxygen. She said she did not notice that there was no order for the resident's oxygen use. She said there should be order in everything done for the resident. 2. Record review of Resident #19's Face Sheet, dated 03/11/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with obstructive sleep apnea (a sleep disorder where breathing is interrupted repeatedly during sleep). Record review of Resident #19's Quarterly MDS Assessment, dated 01/30/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 01 (resident required significant assistance and support in daily life). The Quarterly MDS Assessment indicated that the resident was on non-invasive mechanical ventilator (respiratory support such as CPAP). Record review of resident #19's Comprehensive Care Plan, dated 06/12/2024, reflected the resident had breathing difficulty related to sleep apnea and one of the interventions was the resident to wear CPAP (continuous positive airway pressure: machine used to deliver pressurized air through a mask to keep airways open) every night. Record review of Resident #19's Physician Order, dated 10/26/2023, reflected APPLY auto CPAP 18 & 7 every evening and night shift. Observation on 03/11/2025 at 9:38 AM revealed Resident #19 was not inside the room. It was observed that the resident had a CPAP machine on her right-side table with a CPAP mask was attached to it. The CPAP mask was not bagged. Observation and interview on 03/11/2025 at 9:47 AM, LVN D stated Resident #19 used CPAP at night because the resident had a diagnosis of sleep apnea. She said she would sometimes take off the resident's CPAP in the morning. She said when she did her morning round, the CPAP mask was already off, and she was not aware if somebody took it off before she came, or the resident refused to put it on the night before. LVN D went inside the resident's room and saw the CPAP mask was on top of the table and was not bagged. She said she saw the resident did not have the CPAP mask but failed to check if the mask was inside a plastic bag. LVN D took the CPAP and placed it inside a plastic bag that she took from the resident's drawer. She said she would get another plastic bag and would clean the CPAP mask before putting it inside the new plastic bag. Observation and interview on 03/12/2025 at 7:53 AM, ADON A stated Resident #19's CPAP mask should be bagged when the resident was not using it to prevent it from contact of anything dirty. She said it should not be on the table or in the drawer but inside a plastic bag. She said not bagging the CPAP mask could result to respiratory infection. ADON A said if Resident #2 was using oxygen, there should be an order for oxygen. ADON A logged on to her computer and went to Resident #2's physician orders and saw there was no order for oxygen use. She said the resident had been with oxygen for months and did not know why an order was not in place. She said the nurses were responsible in transcribing the order. She said she would go ahead and make an order for the resident's oxygen therapy because the resident needed due to her emphysema (lung condition that damages the air sacs). She said the expectation was for the staff to bag the CPAP mask after taking it off or when the resident was not using it and a physician order would be in place as appropriate. She said she would remind the staff to bag the CPAP mask and to coordinate with the DON for an in-service regarding bagging the CPAP mask when not in use and make sure there was order for oxygen. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/12/2025 at 12:36 PM, the DON stated the CPAP 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 there should be an order for everything done for the residents, whether medications, treatment, diet, and therapy. She said if Resident #19 was using oxygen, an order for it should be in place. She said the physician orders served as a communication tool for the medical care that a resident needed. She said without an order, the staff caring for the resident would not know the needed interventions with regards to the resident's oxygen use. She said the expectation was for the staff to make sure the CPAP mask was bagged when the resident was not using it and to be mindful if the care or services being provided had orders. She said she would conduct an in-service about respiratory care and physician order. In an interview on 03/12/2025 at 1:13 PM, the Administrator stated everything the residents were using should be kept clean to prevent probable infection. He said there should be order about everything done for the residents. He said he would coordinate with the DON to educate and re-educate the nursing staff to bag the CPAP mask if not in use and make sure there was physician order for oxygen if the resident was using one. 3. Record review of Resident #39's Face Sheet, dated 02/13/2025, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #39 had diagnoses which included shortness of breath and dysphagia (difficulty swallowing) following a cerebral infarction (stroke). Record review of Resident #39's Quarterly MDS Assessment, dated 02/11/2025, reflected the resident had moderative cognitive impairment with a BIMS score of 9 (resident may need additional support and monitoring). Section O did not reflect the resident used oxygen therapy. Record review of Resident #39's Comprehensive Care Plan, dated 02/05/2025, reflected the resident had a stroke. One intervention was Activity as tolerated. OOB in chair if tolerated. The Comprehensive Care Plan did not reflect the resident used oxygen therapy. Record review of Resident #39's Physician Orders, dated 02/03/2025, reflected OXYGEN @ 2 lpm via N/C OR FACE MASK TO MAINTAIN O2 SATS GREATER THAN 90% FOR SOB PRN every 8 hours as needed for SOB, O2 Sats. An observation on 03/11/2025 at 9:40 AM revealed Resident #39 lying in bed asleep. A portable oxygen tank was in the corner of Resident #39's room. Oxygen tubing was connected to the oxygen tank. The oxygen tubing was not bagged. In an interview on 3/11/25 at 09:55 AM, ADON A stated Resident #39 had used oxygen the previous Friday before he went to the hospital. ADON A stated she would remove the tubing from the room and throw it away. She stated the resident did not routinely use oxygen. ADON A stated it was only used at that time because his oxygen saturation was low. She stated oxygen tubing should be stored in a plastic bag when it was not in use. In an interview on 03/11/25 at 10:00 AM, LVN D stated Resident #39 had a PRN order for oxygen. She stated Resident #39 was sent to the hospital with low oxygen saturation. LVN D stated oxygen tubing should be stored in a bag or thrown away if it was not in use. LVN D stated it was important to keep the oxygen tubing covered to prevent infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/13/25 at 10:49 AM, the DON stated if oxygen tubing was not in use, the staff should have made sure it was stored in a bag. The DON stated if the resident does not routinely use oxygen and it was used PRN, it should have been removed and discarded when it was longer needed. She stated if a resident takes the tubing out of the bag, nurses educate the resident on why it is important to keep it covered. The DON stated if a resident were confused and noncompliant, the staff would care plan it. The DON stated it was important to keep oxygen tubing covered so it was kept clean. She stated this was an important infection control measure. The DON stated she had already started in-servicing staff to ensure respiratory items were stored in bags when not in use. In an interview on 03/13/25 at 12:05 PM, CNA G stated it was important to keep respiratory items bagged to prevent cross-contamination. She stated if the oxygen tubing came in contact with something and then the resident put it in their nose, it could cause infection. 4. Record review of Resident #67's face sheet, dated 03/13/25, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #67's relevant diagnoses included sleep apnea (sleep disorder), and acute and respiratory failure with hypoxia (low oxygen levels). Record review of Resident #67's Quarterly Minimum Data Set, dated dated dated [DATE], reflected, he had a Brief Interview for Mental Status score of 15 (intact cognitive response) and for active diagnosis it reflected sleep apnea. Record review of Resident #67's Comprehensive care plan, dated 02/13/25, reflected the resident required the use of a sleep apnea machine for sleep apnea obstruction. Record review of Resident #67's Physician Order, dated 03/11/25, reflected no physician orders for the sleep apnea machine. In an Observation and interview on 03/11/25 at 09:00 AM, LVN A observed Resident #67's CPAP mask stored in the resident's nightstand, unbagged. The LVN stated the resident's CPAP mask should have been placed in the bag, which was sitting under the CPAP mask. He stated the risk of not bagging the resident's CPAP mask when not in use, could result in an infection. In an interview on 03/12/25 at 10:00 AM, the DON was advised of Resident #67 not having physician orders on file for the CPAP machine and his CPAP mask not being bagged. She stated the resident required physician orders for his CPAP machine to ensure that it was set up correctly for the resident's use. She stated the risk of the resident not having the physician orders could result in him not being able to use the CPAP machine correctly for her sleep apnea. She stated the resident's CPAP mask should always be bagged when not in use to avoid contamination. Record review of facility's policy, Respiratory Therapy. (11/2011) revealed The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. 8. Keep the oxygen cannulas and tubing used PRN in a plastic bag when not in use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy Medication and Treatment Orders 2001 Med-Pass, Inc. revised July 2016 revealed Policy Statement: Orders for medications and treatments will be consistent with principles of safe and effective order writing . Policy Interpretation and Implementation . 1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state . 9. Orders for medications must include a. Name and strength of the drug; b. Number of doses, start and stop date, and/or specific duration of therapy; c. Dosage and frequency of administration; d. Route of administration; e. Clinical condition or symptoms for which the medication is prescribed; and f. Any interim follow-up requirements.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 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** 47743 Based on observations, interviews, and record review, the facility failed to ensure that one (Probiotics) of one medication reviewed for Medication Storage was stored properly. 1. The facility failed to ensure MA F administered Resident #26's probiotics that was properly stored. 2. The facility failed to ensure LVN E administered Resident #46' probiotics that was properly stored. These failures could place the residents at risk of not receiving the full benefit of the medications or supplement. Findings included: 1. Record review of Resident #26's Face Sheet, dated 03/12/2025, reflected a [AGE] year-old female admitted on [DATE]. The resident was diagnosed with constipation and nausea. Record review of Resident #26's Comprehensive MDS Assessment, dated 02/03/2025, reflected the resident had a moderate impairment in cognition with a BIMS score of 11 (assessment tool that provides insight into the resident's cognition). The Comprehensive MDS Assessment also indicated the resident had medically complex conditions. Record review of Resident #26's Comprehensive Care Plan, dated 01/25/2025, reflected the resident had nutritional problem and one of the interventions was to administer medications as ordered. Record review of Resident #26's Physician Order, dated 02/20/2025, reflected Acidophilus Oral Capsule (Lactobacillus) Give 1 capsule by mouth one time a day for supplement. Observation on 03/12/2025 at 7:02 AM revealed MA F was preparing Resident #26's medication. After preparing the medications, she went inside the resident's room and administered the medications. It was observed that one of the medications prepared was a probiotic. The bottle of probiotics had a direction at the back that said, Refrigerate after opening. It was also observed that MA F took the bottle of probiotics from the first drawer of cart and returned the bottle of probiotics on the same drawer along with other over-the-counter medications. In an interview on 03/12/2025 at 7:10 AM, MA F stated she did not notice the direction on the bottle of probiotics. She said if the instruction said it should be refrigerated, it should not be in the cart always. She said there was a reason why the manufacturer placed the direction. She said it must have something to do with the effectivity of the probiotics. She said she needed to read the instructions of the medications she was administering to make sure she was administering the right medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #46's Face Sheet, dated 03/12/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with diarrhea and flatulence (release of gas from the digestive system). Review of Resident 46's Comprehensive MDS Assessment, dated 02/25/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 00. Review of Resident #2's Comprehensive Care Plan on 01/07/2025 reflected the resident had nutritional problem and one of the interventions was to administer medications as ordered. Record review of Resident #46' Physician Order, dated 10/14/2025, reflected Lactobacillus Oral Tablet (Lactobacillus) Give 1 tablet . two times a day for ANTIDIARRHEAL. Observation on 03/12/2025 at 7:23 revealed LVN E was preparing Resident #46's medication. After preparing the medications, she went inside the resident's room and administered the medications. It was observed that one of the medication prepared was a probiotics. The bottle of probiotics had a direction at the back that said, Refrigerate after opening. It was also observed that LVN E took the bottle of probiotics from the first drawer of cart and returned the bottle of probiotics on the same drawer along with other over-the-counter medications. Observation and interview on 03/12/2025 at 7:47 AM revealed LVN E read the instruction at the back of the probiotics' bottle and saw that the probiotics should be refrigerated after opening. She stated probiotics should be refrigerated to make sure it would maintain its effectiveness. She took the probiotics from her cart and said she would let ADON A know so she could address the issue about the probiotics. She said she gave the right amount as ordered but did not follow the manufacturer's direction. She said she would let ADON A know so she could address the issue about the probiotics. In an interview on 03/12/2025 at 8:14 AM, ADON A stated she already took all the probiotics from the nurses' and medication aides' carts. She said probiotics were refrigerated because to ensure its potency. She said those probiotics that needed to be refrigerated should not be stored in the cart because it would just render the probiotics ineffective. She said the expectation was to refrigerate the medications and supplements that needed to be refrigerated. She said she already informed the DON about the issue and they already ordered probiotics that do not need to be refrigerated. She said the nurses and herself were responsible for auditing the carts. She would also audit the carts after the interview to see if there were other medications or supplements that needed to be stored inside the refrigerator. In an interview on 03/12/2025 at 12:36 PM, the DON stated she was made aware about the unrefrigerated probiotics. She said some manufactured probiotics needed to be refrigerated to maintain its potency. She said if not refrigerated the probiotics could lose their effectiveness. She said the expectation was for the staff to be mindful of what medications or supplements needed to be stored inside the refrigerator. She said she would do an in-service regarding medication storage. She said she already ordered probiotics that do not need refrigeration and it was already delivered and distributed to the nurses and medication aides. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/12/2025 at 1:13 PM, the Administrator stated the expectation was for the probiotics to be stored inside the refrigerator when the staff were done administering them. He said he believed it has something to do with the effectiveness of the probiotics. He said he would collaborate with the DON on how to prevent the issue from happening again. Record review of facility policy Medication Storage in the Facility Policies and Procedures revised January 2018 revealed Temperature . C. medications requiring refrigeration are kept in a refrigerator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 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. 45055 Based on observation, interview, and record review the facility failed to store, prepare, distributed, and serve food in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food and nutrition services. 1. The facility failed to ensure the ice scoop for the ice machine in the facility kitchen was cleaned and not stored inside the ice machine. 2. The facility failed to cover a large trash can stored in the kitchen area. 3. The facility failed to ensure kitchen cooking equipment was cleaned. 4. The facility failed to place a cover on top of the tea dispenser to avoid air borne contaminants. These failures could place residents at risk for cross contamination and other air-borne illnesses. Findings include: Observations on 03/11/25 from 9:04 AM to 9:17 AM in the facility's only kitchen revealed: The ice machine, located in the kitchen, had the ice scoop stored inside of the machine with the ice and the ice scoop had brownish stains on it. One large trash can, which contained food and trash, in the kitchen area, was uncovered. One large tea dispenser, located in the kitchen area, had tea in it and it did not have a lid placed on the top dispenser to avoid air-borne contaminants. One large microwave, located in the kitchen area, had brownish stains along the inner walls of the microwave. One large deep fryer, located in the kitchen area, had thick dried-up grease along the inner walls of the fryer. In an interview on 03/12/25 at 01:00 PM, the Dietary Manager in Training and the Dietician were shown pictures of the concerns observed in the kitchen area. They stated they would work on resolving the concerns observed. The Dietary Manager in Training stated he would ensure the trash cans hadve the lids fully placed on the trash cans. The Dietician stated they had been previously advised not to store the ice scoop in the ice machine because of sanitary concerns, but the staff forgot and placed it in the ice machine. The DMT stated they cleaned the microwave and frying station weekly. They stated the risk of not resolving these concerns could result in cross contamination. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/13/25 at 11:40 AM, the Administrator was advised of the findings in the kitchen. He stated he expected his kitchen staff to ensure that the kitchen equipment is cleaned regularly and thoroughly to avoid any contaminations. Record review of the facility's policy on Food Safety and Sanitation (2023), revealed All local, state, and federal standards and regulations will be followed to assure a safe and sanitary food and nutrition services department. Record review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 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 #34) of eight residents reviewed for Infection Control. The facility failed to ensure CNA B changed his gloves after touching the drainage tubing of Resident #72's Foley catheter (device that drains urine from the urinary bladder) during incontinent care on 03/11/2025. This failure could place residents at risk of cross-contamination and development of infections. Findings included: Record review of Resident #72's Face Sheet, dated 03/11/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with obstructive and reflux uropathy (a blockage in the urinary tract that cause the urine to flow back to the kidney). Record review of Resident #72's Comprehensive MDS Assessment, dated 01/23/2025, reflected the resident was cognitively intact with a BIMS score of 15 (resident capable of normal cognition and needs little support). 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 bag). Record review of Resident #72's Comprehensive Care Plan, dated 01/23/2025, reflected the resident had and indwelling catheter and one of the goals was the resident will not show signs and symptoms of urinary infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with CNA B on 03/11/2025 at 10:51 AM revealed CNA B was about to change Resident #72 because the resident told CNA B she felt she had a bowel movement. It was observed that the resident had a catheter hanging at the right side of the bed. CNA B washed his hands, put on a pair of gloves, and cleaned the resident's overbed table. After cleaning the resident's overbed table, he placed a new brief, a padding, some wipes, some gloves, and a bottle of sanitizer on the table. He took off his gloves, sanitized his hands, and put on a new pair of gloves. He started by cleaning the lower abdomen of the resident and then the perineal (area between the legs) area of the resident using the front to back technique. After cleaning the perineal area, he assisted the resident to turn to her right side and cleaned the resident's bottom. After cleaning the resident's bottom, he pulled the soiled brief and threw it in the trash can. He also rolled the bed's fitted sheet towards the middle of the bed. He removed his gloves, sanitized his hands, and put on a new pair of gloves. After putting on a new pair of gloves, he took the padding from the overbed table and put it under the resident. He took the brief from the overbed table and put it on top of the padding. CNA B then went to the other side of the bed and assisted the resident to turn to the left side. On the process of turning the resident, CNA B held the tubing of the resident's catheter bag and pulled the other half of the fitted sheet. After pulling the fitted sheet, CNA B proceeded to fix the new padding and the new brief. He did not change his gloves after touching the catheter bag tubing. He said he did change his gloves and sanitized his hands on the on the first part of the incontinent care but did not change his gloves after touching the tubing. He said the tubing is always presumed dirty because the urine flow from it. He said he should have changed his gloves to prevent the transfer of germs from the tubing to the new brief. He said he would be mindful to change his gloves after touching something dirty. Observation and interview on 03/12/2025 at 7:53 AM, ADON A stated CNA B told her he did not change his gloves and sanitize his hands after touching Resident #72's catheter tubing. ADON A said she reminded CNA B to change his gloves after touching something dirty or presumed dirty to prevent cross contamination and infection like urinary tract infection. She said the expectation was for the staff to change their gloves form dirty to clean. She said she would also do an in-service for all the staff. In an interview on 03/12/2025 at 12:36 PM, the DON stated hand hygiene was the most effective way to prevent cross contamination and spread of infection. She said gloves should be changed after touching Resident #72's catheter because his gloves were already deemed dirty. She said the expectation was for the staff to wash their hands before and after any care and change their gloves when going from dirty to clean. She said she was made aware by CNA B about the issue and already started an in-service about when to change their gloves and infection control. In an interview on 03/12/2025 at 1:13 PM, the Administrator stated not changing the gloves from soiled to clean 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. She said the DON already did a one-on-one in-service for CNA B and would also in-service all the staff about infection control. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676448	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy, Infection Control Guidelines for All Nursing Procedure reviewed December 2024 revealed Purpose: To provide guidelines for general infection control while caring for residents . 2. Gloves . a. Wear gloves (clean, non-sterile) when you anticipate direct contact with blood, body fluids, mucous membranes, non-intact skin, and other potentially infected material . c. Wear gloves when handling or touching resident-care equipment that is visibly soiled or potentially contaminated with blood, body fluids, or infectious organisms. e. Change gloves, as necessary, during the care of a resident making sure to sanitize/wash hands in between to prevent cross-contamination from one body site to another (when moving from a dirty site to a clean one).