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	05/21/2026

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observation, interview and record review, the facility failed to provide a private meeting space for the residents' monthly council meetings for 11 of 11 confidential residents reviewed for resident council.The facility failed to provide a private space for resident council meetings. This failure could place residents who attended the resident council meetings at risk of not being able to voice concerns due to lack of privacy. Observation and interview on 05/20/2026 at 11:30 a.m. during a confidential resident group meeting held in a private therapy gym, revealed the meeting was normally held in the upstairs dining room. There were no doors or solid walls that separated the dining room from the open nurses' station or the two hallways leading into the dining room. The residents stated they did not feel they could express their opinions because staff would be able to hear them and that anyone could walk in and out of the dining room area. An interview on 05/20/2026 at 12:20 p.m. with the Activity Director revealed she had been hired in September of 2025 and that she knew the meeting should be held in a private area, but staff told her it had always been held in the upstairs dining room so she continued to have it there. She was not aware the residents had voiced any concerns about the meeting. An interview on 05/21/2026 at 4:35 p.m. with the Administrator revealed he expected the meeting to be held in a private area so the residents could voice concerns and the risk to not having the meeting in a private area could keep the residents from speaking freely or the wrong person could hear something. The facility did not have a specific policy regarding privacy of the Resident Council meetings.

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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(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 - Some	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** Based on observation, interview, and record review the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for six of twenty residents (Residents #29, #44, #70, #74, #78, and #86) and one of three carts (Nurse Cart) reviewed for medication storage. 1.The facility failed to ensure that Resident #78's eye drops were not accessible to other residents on 05/19/2026. 2.The facility failed to ensure that Resident #70 analgesic topical gel was not inside his room on 05/19/2026. 3.The facility failed to ensure that Resident #86 did not have a tube of zinc oxide inside her room on 05/19/2026. 4.The facility failed to ensure that Resident #29 did not have a tube of zinc oxide inside his room on 05/19/2026. 5.The facility failed to ensure that Resident #44 did not have an antifungal powder tube inside her room on 05/19/2026. 6.The facility failed to ensure that Resident #74 did not have a tube of zinc oxide inside her room [ROOM NUMBER]/19/2026. 7.The facility failed to ensure that a bottle of probiotics with an instruction of Refrigerate after opening was stored inside the cart since it was opened on 02/10/2026. These failures could place the residents at risk of accidental overdose, misuse of medications, and possible adverse reactions.Findings included: 1.Record review of Resident #78's Face Sheet, dated 05/20/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dry eye syndrome (insufficient tear production). Record review of Resident #78's Comprehensive MDS Assessment, dated 04/03/2026, reflected that the resident had an intact cognition with a BIMS score of 14. The Comprehensive MDS Assessment indicated that the resident had dry eye syndrome. Record review of Resident #78's Comprehensive Care Plan, dated 04/01/2026, reflected that the resident rights will be respected and one of the interventions was to receive care, as necessary. Record review of Resident #78's Physician Order, dated 03/18/2026, reflected Artificial Tears Ophthalmic Solution 0.5-0.6 % (Polyvinyl Alcohol-Povidone (Ophth)) Instill 1 drop in both eyes every 12 hours as needed for DRY EYES EYE DROPS TO SELF ADMININSTER AT BEDSIDE PER MD. Record review of Resident #78's Self-Administration of Medication, dated 02/26/2026, reflected that the resident could safely administer her medications. During an observation and interview on 05/19/2026 at 9:05 a.m., revealed Resident #78 was in her bed, awake. It was observed that a container of eye drops was in her overbed table. The eye drops were in plain view, was accessible, and visible from the hallway. The resident said she would apply it to her eyes and would always put it on her overbed table. 2.Record review of Resident #70's Face Sheet, dated 05/20/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with unspecified pain. Record review of Resident #70's Comprehensive MDS Assessment, dated 03/02/2026, reflected that the resident had an intact cognition with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident would experience pain occasionally. Record review of Resident #70's Comprehensive Care Plan, dated 03/22/2026, reflected that the resident was on pain medication and one of the interventions was to administer medications as ordered. Record review on 05/19/2026 of Resident #70's Clinical Assessment Notes reflected no assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications. During an observation and interview on 05/19/2026 at 9:09 a.m., revealed Resident #70 was in his wheelchair, awake. It was observed that a tube of topical analgesic gel was on top of the resident's side table. The analgesic gel was visible from the hallway and was on a plain view. The resident said the gel was for his hip and also for other parts of his body that was hurting. He said LVN B would get from the tube and apply it to him and then would leave it on his table. 3.Record review of Resident #44's Face Sheet, dated 05/21/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was diagnosed with rash and other nonspecific skin eruptions. Record review of Resident #44's Comprehensive MDS Assessment, dated 02/23/2026, reflected that the resident had an intact cognition with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had rash and other nonspecific skin eruptions. Record review of Resident #44's Comprehensive Care Plan, dated 05/14/2026, reflected that the resident was having rashes and one of the interventions was to administer medications as ordered. Record review of Resident #44's Physician Order, dated 05/13/2026, reflected Cleanse rash to abd and chest with ns, pat dry, apply anti [NAME] cream and leave open to air qd and prn every day shift for Skin/Wound support related to RASH AND OTHER NONSPECIFIC SKIN ERUPTION. Record review on 05/19/2026 of Resident #44's Clinical Assessment Notes reflected no assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications. During an observation and interview on 05/19/2026 at 9:30 a.m., revealed Resident #44 was in her bed, awake. It was observed that an antifungal powder was on top of her overbed table. She said the staff used the powder on her abdomen, and the powder was always left on her table. During an observation and interview on 05/21/2026 at 11:57 a.m., LVN B said she did not know about Resident #78's eye drops and she did not notice it during her round. She said she knew about Resident #70 having analgesic gel inside the room but did not question it. Said Resident #70 had an order for the analgesic gel, and he had one inside the cart. She said she would sometimes get from the tube inside the room. She said she was not sure if Resident #70 would apply some more gel on top of what she was administering. She said medications inside the room might cause overdosing, and the staff would not know how many times it was applied by the residents. She said even the pain-relieving gel could cause skin irritation depending on how often it was used. She said she would check the medications mentioned. 4.Record review of Resident #86's Face Sheet, dated 05/21/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness. Record review of Resident #86's Comprehensive MDS Assessment, dated 05/16/2026, reflected that the resident was cognitively intact with a BIMS score of 14. The Comprehensive MDS Assessment indicated the resident was incontinent (unable to control) for bowel. Record review of Resident #86's Comprehensive Care Plan, dated 05/17/2026, reflected that the resident had an ADL Self Care Performance deficit and one of the interventions was to assist during toilet use. Record review on 05/19/2026 of Resident #86's Clinical Assessment Notes reflected that the resident did not have an assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications. During an observation on 05/19/2026 at 9:24 a.m., revealed Resident #86 was in her bed with eyes closed. It was observed that a tube of zinc oxide was on top of the resident's side table. 5.Record review of Resident #29's Face Sheet, dated 05/21/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness. Record review of Resident #29's Comprehensive MDS Assessment, dated 05/03/2026, reflected that the resident had severe impairment in cognition with a BIMS score of 05. The Comprehensive MDS Assessment indicated the resident was incontinent for bowel and bladder. Record review of Resident #29's Comprehensive Care Plan, dated 05/10/2026, reflected that the resident had an ADL Self Care Performance deficit and one of the interventions was to assist during toilet use. Record review on 05/19/2026 of Resident #29's Clinical Assessment Notes reflected that the resident did not have an assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications. During an observation and interview on 05/19/2026 at 9:26 a.m., Resident # was in his bed, awake. It was observed that a tube of zinc oxide was on top of his side table. When asked if what the zinc oxide was for, the resident shrugged his shoulder. During an interview on 05/19/2026 at 9:34 a.m., CNA D said she was not the one who left the tube of zinc oxides on Resident #29 and Resident #86's side table. She said the staff used the zinc oxide when they cleaned them and changed their briefs. She said it should not be within reach of residents because some residents were confused and might eat the cream. 6.Record review of (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #74's Face Sheet, dated 05/21/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body). Record review of Resident #74's Comprehensive MDS Assessment, dated 05/01/2026, reflected that the resident had a moderate impairment in cognition with a BIMS score of 10. The Comprehensive MDS Assessment indicated the resident was incontinent for bladder and bowel. Record review of Resident #74's Comprehensive Care Plan, dated 04/06/2026, reflected that the resident had mixed incontinence and one of the interventions was to check the resident every two to four hours and as required for incontinence. Record review on 05/19/2026 of Resident #74's Clinical Assessment Notes reflected no assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications. During an observation and interview on 05/19/2026 at 11:41 a.m., revealed Resident #74 was in her bed, awake. It was observed that a tube of zinc oxide was on top of the resident's side drawer and was in plain view. She said the staff would use it when they changed her. She said the staff always leave the tube for zinc oxide on top of her side table and very seldom put it in her drawer. During an observation and interview on 05/19/2025 at 11:44 a.m., LVN C said the tube of barrier cream should not be left inside the room or should be accessible to the residents because they might think that it was something edible and consume it or apply it to the face and eyes. She called CNA F and talked to her about Resident #74's barrier cream. During an interview on 05/19/2026 at 11:47 a.m., CNA F said she left the barrier cream on top of Resident #74 drawer because she was in a hurry to get the other residents up. She said it should not be accessible to the residents because residents that were confused might put it in their eyes and mouth. 7.During an observation on 05/20/2026 at 12:05 p.m., revealed a bottle of probiotics with an instruction at the back that said, Refrigerate after opening was inside the drawer of LVN B's cart. The probiotics had an opening date of 02/10/2026. During an observation and interview on 05/20/2026 at 12:06 p.m., revealed LVN B read the instruction at the back of the bottle of probiotics and said the instruction was said to refrigerate after opening. She said the probiotics were opened last February and had always been inside the cart since then. She said she did not notice the direction on the bottle. She said if the instructions said it should be refrigerated, then it should not be inside the cart. She said there was a reason why the manufacturer placed the direction, and it must have something to do with the effectiveness of the probiotics. She said she was responsible in checking which medication should be inside the refrigerator. During an interview on 05/21/2026 at 7:20 a.m., ADON A said barrier creams with zinc oxide should not be within reach of the residents. She said confused residents might mistakenly consume them or use them inappropriately. She said the barrier creams should be somewhere not accessible to the residents. She said medications, such as topical analgesic, should not be inside the residents' rooms for the same reason. She said Resident #78 had an order that stated she could administer her eye drops, but the eye drops should not be accessible to the other residents. She said she would check on Resident #44's antifungal powder was on plain view. She said they would start an in-service about medication storage. During an interview on 05/21/2026 at 8:16 a.m., the DON said medications, whether oral or topical, should not be inside the residents' rooms because the residents might use them inappropriately and that could result in adverse reactions. She said skin barriers were applied topically and could be harmful when ingested. She said the expectation was for the staff to be vigilant when they entered the residents' room to check for any medications and for staff using the skin barriers to not leave the tubes within reach of the residents. She said she would start an in-service to re-educate the staff about medication storage. During an interview on 05/21/2026 at 9:01 a.m., the Administrator-in-Training said the expectation was for the staff to make sure there were no medications and barrier creams inside the residents' rooms because the residents might consume them or use them inappropriately. He said he would coordinate with the DON about the issue. Record review of facility policy Medication Storage in the Facility Policies and Procedures revised January 2018 revealed Temperature . C. medications requiring refrigeration are (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	kept in a refrigerator. 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.

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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. Based on observation, interviews, and record reviews, the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for food and nutrition services. The facility failed to ensure all food items in the facility's kitchen were dated and discarded prior to their use-by date and were properly sealed. These failures could place residents at risk of food contamination and food-borne illness.Finding included: An observation on 05/19/26 between 9:15 AM and 9:45 AM in the facility's kitchen revealed:One gallon bag containing pasta noodles with an expiration date of 05/17, not properly sealed and exposed to air contaminants. One gallon bag containing two graham pie crusts was undated and revealed no expiration date. One gallon bag containing three graham pie crusts was undated and revealed no expiration date. One bag containing brown sugar dated 05/15/26 with no visible expiration date. One head of lettuce dated 05/18/26 with no visible expiration date was observed. One gallon bag containing two frozen beef patties dated 05/19/26 with no visible expiration date. During an interview on 05/21/26 at 11:35 AM, the DM verbally acknowledged he state surveyor observations and stated the listed items would be corrected. The DM stated once items were opened, they should be properly sealed and dated. The DM stated he was responsible for ensuring policy was followed. The DM stated he and one other kitchen aide was responsible for proper labeling and making sure that the items were labeled properly. The DM stated the risk to residents if policy was not followed was a health risk to the residents. The DM stated the items should be labeled, and the risk of the concerns not being addressed could result in food-borne illnesses. The DM stated if food items were not dated when opened, then they would not know how long the item would last. The DM stated a full in-service completed in reference to food rotation and storage pertaining to what the proper procedures were dealing with food rotation and storage. The DM stated the risk of serving foods that were past the use-by date, or serving food that was not labeled or dated, could cause food borne illness. During an interview on 05/21/2026 at 1:45 PM, the AIT stated he oversaw all departments, and ensured residents were taken care of. The AIT said the policy or procedure for storing food was, everything needed to be dated, and if opened, it needed to have an open date and an expiration date. He said the risk to residents if policy were not followed, was they could get sick from food borne illnesses. The AIT stated he would expect the DM to ensure that the kitchen followed all guidelines, including ensuring the food items were labeled properly in the kitchen. The AIT stated he expected staff to ensure they were following policies and procedures of the facility kitchen policy, to protect residents and to deliver good care. Record review of the facility's undated Policy and Procedure Manual Food Storage, 7. All stock must rotated with each new order received. Rotating stock is essential to assure the freshness and highest quality of all foods. a. Old stock is always used first (first in - first out method or FIFO). The person designated to manage stock should be trained to rotate it properly.b. Food should be dated as it is placed on the shelves if required by state regulation.c. Date marking should be visible on all high risk food to indicate the date by which a ready-to-eat TCS food should be consumed, sold, or discarded. Review of TITLE 21--FOOD AND DRUGS CHAPTER I--FOOD AND DRUG ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICESSUBCHAPTER B - FOOD FOR HUMAN CONSUMPTION PART 110 -- CURRENT GOOD MANUFACTURING PRACTICE IN MANUFACTURING, PACKING, OR HOLDING HUMAN FOOD.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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 four of twenty residents (Residents #11, #46, #51,and #87) reviewed for infection control. 1.The facility failed to ensure LVN C performed hand hygiene when she suctioned, changed the tracheostomy's inner cannula, changed the g-tube's dressing, and changed Resident #11's feeding formula on 05/20/2026. 2.The facility failed to ensure CNA D wore a gown while changing Resident #46's linen, who had a midline IV (a thin tube inserted into the vein for delivery of medications) and pressure ulcer, on 05/19/2026. 3.The facility failed to ensure CNA D and the DOR wore gowns and performed hand hygiene when they performed Resident #51's incontinent care, who had an open wound, on 05/19/2026. 4.The facility failed to ensure CNA E wore a gown when she transferred Resident #87 and changed her clothes, who had a fistula and catheter, on 05/20/2026. These failures could place residents at risk of cross-contamination and development of infections. Findings included: 1.Record review of Resident #11's Face Sheet, dated 05/21/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with tracheostomy (is an opening surgically created through the neck into the windpipe to allow air to fill the lungs) and gastrostomy status. Record review of Resident #11's Comprehensive MDS Assessment, dated 05/14/2026, reflected that the resident had a severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident was receiving tracheostomy care, was being suctioned (mechanical aspiration of pulmonary secretions to clear the airway), and had a feeding tube. Record review of Resident #11's Care Plan, dated 04/12/2026, reflected:- the resident had a tracheostomy, and the interventions were to ensure that the trach ties were always secured and to suction, as necessary.- the resident required tube feeding and one of the interventions was to provide tube feeding and flushes. Record review of Resident #11's Physician Order, dated 01/06/2026, reflected May suction for removal of secretions as needed. Record review of Resident #11's Physician Order, dated 12/25/2026, reflected Change Disposable Inner Cannula . using clean technique Daily and PRN. one time a day. Record review of Resident #11's Physician Order, dated 11/04/2026, reflected Cleans GT site with NS daily and apply barrier cream under bumper Keep Bumper tight against skin to prevent movement ay insertion site one time a day for GT care. Record review of Resident #11's Physician Order, dated 03/11/2026, reflected Enteral Feed Order every shift Jevity 1.2 cal 64 cc/hr X 22 hrs, with 150 ml water flush q 6 hrs. Monitor for Increased residual. Notify ADON. During an observation on 05/20/2026 at 9:28 a.m., LVN C prepared to suction Resident #11 and change his trach ties and feeding formula. She washed her hands and put on a pair of gloves. She sanitized the resident's overbed table, put a sheet of wax paper on top of the suction tip, the disposable inner cannula, two bottles of normal saline, some large cups, trach tie, a bottle of feeding formula, a syringe, and some gauzes. She removed her gloves, washed her hands, and put on a pair of gloves and a gown. She turned off the g-tube pump and took off the breathing mask on top of the resident's tracheostomy. She removed her gloves and put on another pair of gloves; no hand hygiene was done. She took the new trach ties and put a date on them. She changed her gloves again with no hand hygiene, turned on the suction machine, and started a sterile technique (a controlled practice to eliminate all microorganisms). She then opened a tracheostomy suction kit, opened a bottle of normal saline, and took off her gloves. She then took the package of sterile gloves from the kit and opened the outer wrapper by peeling back the edges of the wrapper. With her left hand, she grasped the folded inner surface of one glove and inserted her right hand and pulled the glove over the wrist. She then put on the second glove to her left hand by slipping her fingers under the cuff of the second glove, inserted the left hand, pulled it over to the wrist, and adjusted the sterile gloves on both hands. She removed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the suction catheter with one hand, attached it to the catheter tip, and tested if it was working by dipping it in normal saline. She then inserted the catheter, applied suction while withdrawing the catheter in a rotating motion. After suctioning the resident, she took off her sterile gloves, put on a clean pair of gloves, and changed the resident's trach ties. After changing the trach ties, she took off her gloves and proceeded to change the inner cannula using again the sterile technique. After changing the inner cannula, she took off her gloves and put on a new pair of gloves. She then hung the new container of feeding formula and primed it. After priming the formula, she changed her gloves and checked for g-tube placement. She then took the syringe to check for the gastric residual. After checking for the residual and placement, she flushed the g-tube and connected the formula. After connecting the formula, she took off her gloves, put on a pair of gloves, and changed the g-tube dressing. She did not sanitize her hands between changing of gloves when she disconnected the g-tube, took off the breathing mask, changed the trach tie, changed the formula, and changed the g-tube dressing. She also did not sanitize her hands before putting on the sterile gloves. During an interview on 05/20/2026 at 10:20 a.m., LVN C said she knew she was supposed to sanitize her hands when she was changing her gloves to prevent cross contamination and infection control. She said Resident #11's family member only wanted her to change her gloves and not sanitize between changing gloves. She said, but she knew, hands should be sanitized when they were changing their gloves. She said sterile technique should be used during suctioning and when changing the inner cannula of the resident's tracheostomy. During an interview on 05/20/2026 at 10:22 a.m., Resident #11's family member said she did not tell her not to sanitize her hands when she was changing her gloves. She said if it was the right thing to do to help the resident, then it should be done. She said it was not the first time that LVN C did not sanitize her hands when changing her gloves. 2.Record review of Resident #46's Face Sheet, dated 05/21/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with a pressure ulcer (wound on the skin caused by prolonged pressure to specific areas of the body) to the sacral region (bone at the buttocks). Record review of Resident #46's Comprehensive MDS Assessment, dated 05/02/2026, reflected that the resident was cognitively intact with a BIMS score of 14. The Comprehensive MDS Assessment indicated that the resident was receiving an antibiotic and had a pressure ulcer. Record review of Resident #46's Comprehensive Care Plan, dated 04/28/2026, reflected that the resident was on antibiotic therapy and had a wound. The intervention for both was to administer antibiotics as ordered. Record review of Resident #46's Comprehensive Care Plan, dated 04/28/2026, reflected that the resident had a condition that required enhanced barrier precautions and one of the interventions was to don gown and gloves after entering the room to provide high contact resident care activities such as dressing, bathing/showering, transfers, providing hygiene, changing linens, toileting/brief changes, device care, med administration via enteral tube or central line, trach care and wound care. Record review of Resident #46's Physician Order, dated 05/14/2026, reflected Daptomycin (antibiotic for bacterial infections) Intravenous Solution Reconstituted (Daptomycin) Use 550 gram intravenously every 48 hours for Wound infection until 5/22/2026 until 05/22/2026 23:59. Record review of Resident #46's Physician Order, dated 05/12/2026, reflected Flush each port of the MIDLINE (a device inserted in the veins used for treatment) with 10 MLs of NS Q Shift both before and after medication administration. every shift. Record review of Resident #46's Physician Order, dated 04/28/2026, reflected Resident is on EBP and Standard Precautions R/T . MIDLINE and PRESSURE ULCER every shift for Enhanced barrier precautions medical condition Staff must don (put on) gown & gloves when performing high contact care such as bathing/showering, pericare (hygiene practices involved in cleaning the area between the thighs)/brief changes, dressing changes, meds via enteral tube or central line, toileting, transfers, providing hygiene, changing linens, device care. Record review of Resident #46's Physician Order, dated 05/08/2026, reflected Cleanse stage 4 to left fold buttocks with ns, pat dry, pack wound with Dakin moist kerlix and dry dressing qd and prn everyday shift for Skin/Wound support. During an observation on 05/19/2026 at 9:31 a.m., CNA D was inside Resident (continued on next page)

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	676448	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	1610 Richardson Dr Richardson, TX 75080

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#46's room and was changing the resident's linen without a gown. It was observed that the resident had a midline IV catheter to his right upper arm. It was observed that there was a sign outside that the resident was on enhanced barrier precautions. During an interview on 05/19/2026 at 9:36 a.m., Resident #46 said he had an infected wound on his buttocks; that was why he was on antibiotics. 3.Record review of Resident #51's Face Sheet, dated 05/21/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with pressure-induced deep tissue damage (pressure ulcer) of the sacral region. Record review of Resident #51's Comprehensive MDS Assessment, dated 04/27/2026, reflected that the resident had a severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated that the resident had an unstageable (unable to determine the depth of the wound) pressure ulcer. Record review of Resident #51's Comprehensive Care Plan, dated 04/27/2026, reflected that the resident had a documented pressure ulcer and one of the interventions was to provide wound care. Record review of Resident #51's Physician Order, dated 04/24/2026, reflected Cleanse unstageable to left heel with ns, pat dry, apply medihoney and cal alg and dry dressing q M-W-F and prn every day shift every Mon, Wed, Fri for Skin/Wound support related to RASH AND OTHER NONSPECIFIC SKIN ERUPTION. Record review of Resident #51's Physician Order, dated 05/07/2026, reflected cleanse unstageable to sacral region with ns, pat dry, apply medihoney and cal alg and dry dressing qd and prn every day shift for Skin/Wound support related to RASH AND OTHER NONSPECIFIC SKIN ERUPTION. There was no order for EBP. During an observation on 05/19/2026 at 1:53 p.m., CNA D and the DOR provided Resident #51 with incontinent care. CNA D washed her hands and put on a pair of gloves she did not put on a gown. The DOR put on a pair of gloves but did not do hand hygiene and did not wear a gown. CNA D took off the resident's pants, removed her gloves, washed her hands, and put on a pair of gloves. CNA D unfastened the resident's brief, and the DOR pushed the brief between the resident's legs. CNA D cleaned the resident's perineal area (area between the legs), took off her gloves, washed her hands, and put on a pair of gloves. They then rolled the resident, CNA D cleaned the resident's bottom. After CNA D cleaned the resident's bottom, she took off her gloves, washed her hands, and put on a pair of gloves. The DOR took the brief, opened it, and handed it over to CNA D. The DOR did not change her glove after touching the soiled brief and before opening the brief. It was observed that the resident had a dressing to his bottom. It was also observed that there was no sign outside the door indicating that the resident was on EBP and there was no PPE cart. During an interview on 05/19/2026 at 2:19 p.m., CNA D said she was supposed to wear a gown when she changed Resident #46's linen because he had an IV and wound, but she forgot. She said she needed to wear a gown to protect the resident from infection. She said she did not know if she needed to wear a gown for Resident #51. During an interview on 05/19/2026 at 2:25 p.m., the DOR said she was supposed to change her gloves after touching Resident #51's soiled brief to prevent cross contamination. During an interview on 05/19/2026 at 2:43 p.m., the ADON said Resident #51 was on EBP before for diarrhea, but the loose bowel movement was already resolved. She said the resident had an open wound, so she believed the resident should still be on EBP, but she would check with the wound care nurse. During an interview on 05/19/2026 at 2:56 p.m., the Administrator-in-Training said as per their policy, if the wound did not have a drainage, EBP was not required. During an interview on 05/21/2026 at 1:38 p.m., the WCN said she was told by the Administrator a month ago that residents with wounds that did not have drainage did not require EBP. She said on the afternoon of 05/19/2026, she was told that Resident #51 required EBP, that was why she put back the EBP sign and the PPE cart. She said the Administrator-in-Training told her to put the EBP sign and PPE cart.During an interview on 05/21/2026 at 11:21 a.m., the DOR said she was told that gown should have been worn when they cared for Resident #51 because he had a wound, She said the purpose of the gown was to prevent spread of microorganisms. 4.Record review of Resident #87's Face Sheet, dated 05/21/2026, reflected a [AGE] year-old female re-admitted to the facility on [DATE]. The resident was diagnosed with neuromuscular dysfunction of bladder and acute kidney failure (kidneys stopped working). (continued on next page)

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	676448	A. Building B. Wing	05/21/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #87's Comprehensive MDS Assessment, dated 04/29/2026, reflected that the resident had a moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment indicated that the resident had an indwelling catheter and was undergoing dialysis (a medical treatment that removes waste products from the blood). Record review of Resident #87's Comprehensive Care Plan, dated 05/20/2026, reflected that the resident had an indwelling catheter and was undergoing dialysis. The interventions were to provide catheter care and check the dialysis site. Record review of Resident #87's Physician Order, dated 05/19/2026, reflected Keep urinary drainage bag below the level of the bladder at all times every shift related to NEUROMUSCULAR DYSFUNCTION OF BLADDER, UNSPECIFIED. Record review of Resident #87's Physician Order, dated 05/19/206, reflected Monitor Dialysis Access Site: PERMACATH (a thin tube inserted in the vein to allow cleaning of the blood) every shift related to END STAGE RENAL DISEASE (a condition where the kidneys can no longer function adequately). During an observation on 05/20/2026 at 8:39 a.m. revealed CNA F was about to transfer Resident #87 to her recliner. Before she transferred the resident, she changed the resident's clothing. She did not have a gown when she changed the resident and when she transferred to her wheelchair. During an interview on 05/20/2026 at 11:37 a.m., CNA F said she knew she was supposed to wear a gown when she changed and transferred Resident #87 because she had a catheter and was going to dialysis. She said she needed to wear a gown to prevent infection. During an interview on 05/21/2026 at 7:20 a.m., ADON A said the staff should do hand hygiene when they were changing their gloves to prevent cross contamination. She said the staff should change their gloves after touching the soiled brief and before touching the new brief for the same reason. She said gowns were required when caring for residents with wounds, mid-line IV, fistula, and catheter to prevent infection. She said they would do an in-service about infection control. During an interview on 05/21/2026 at 8:16 a.m., the DON said if a resident was on EBP, then the staff doing care should wear a gown every time they had contact with the resident to prevent cross contamination and spread of infection. She said EBP was required in addition to the gloves when caring for a resident that had a wound, a midline, a fistula, and a catheter. She said gowns should have been worn when the staff changed Resident #46's linen who had a pressure ulcer and a midline, when they did resident #51's incontinent care, who had an open wound, and when they changed and transferred Resident #87 who had a fistula and catheter. She said for Resident #51, they came to the conclusion that he required EBP because he had a wound that required dressing change. She said gloves should have been changed after touching the soiled brief because the gloves were already deemed dirty and could contaminate the new brief. She said the concerns discussed were all infection control issues. She said the expectation was for the staff to wear a gown when needed and to change their gloves after touching anything dirt. She said she would start an in-service to re-educate the staff about infection control. During an interview on 05/21/2026 at 9:01 a.m., the Administrator-in-Training said the expectation was for the staff to be mindful not to spread any infection and that the staff would adhere to the policy of infection control. He said residents with wounds that needed dressing change, midline IV, pressure ulcers, and catheters should require EBP. He said he would coordinate with the DON about the infection control issues. Record review of the facility's policy Enhanced Barrier Precautions reviewed December 2025 reflected Policy Statement: Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistance organisms that employs targeted gown and glove use during high contact resident care activities . Policy Interpretation and Implementation . apply to the care of all residents in the facility . wounds and/or indwelling medical devices . Enhanced Barrier Precautions include the following practices . 4. Gowns . a. Wear a gown (clean, non-sterile) to protect skin and prevent soiling of clothing during high contact resident care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, colostomy care, medication administration via g-tube, and device care or use: central line, urinary catheter, feeding tube, tracheostomy ., wound care: any skin opening requiring a dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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).

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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** 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 #87) of nineteen residents reviewed for dignity. The facility failed to treat Resident #87 with dignity and promote enhancement of their quality of life when the resident was not provided a privacy bag for her catheter bag on 05/20/2026. This failure could place the residents at risk of not having their right to a dignified existence maintained.Findings included: Record review of Resident #87's Face Sheet, dated 05/21/2026, reflected a [AGE] year-old female re-admitted to the facility on [DATE]. The resident was diagnosed with neuromuscular dysfunction of the bladder (the muscles and nerves that control the bladder do not work properly due to illness). Record review of Resident #87's Comprehensive MDS Assessment (assessment used to determine functional capabilities and health needs), dated 04/29/2026, reflected that the resident had a moderate cognitive impairment (resident may need additional support and monitoring) in cognition with a BIMS (screening tool used to assess cognitive status) score of 12. The Comprehensive MDS Assessment indicated that 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 #87's Care Plan, dated 05/20/2026, reflected that the resident had an indwelling catheter and one of the interventions was to provide catheter care. Record review of Resident #87's Physician's Order, dated 05/19/2026, reflected Monitor Foley (device used to help drain urine from bladder) Catheter Q Shift for leakage, blockage, sediment buildup, or low output. Every shift. During an observation on 05/20/2026 at 8:35 a.m. revealed Resident #87 was in her bed, awake. It was observed that the resident had a catheter bag hanging on the side frame of the bed. The catheter bag did not have a privacy bag, and the bag and the urine inside the bag could be seen from the hallway. During an interview on 05/20/2026 at 8:55 a.m., Resident #87 said she had a catheter because her kidneys were not working right. She said she only had the catheter on her last hospitalization. During an interview on 05/20/2026 at 11:21 a.m., LVN B said Resident #87 just came back from the hospital and was re-admitted to the facility with the catheter. She said she did not notice that the resident's catheter bag did not have a privacy bag. She said the facility used a catheter bag with a flap so that they did not need to put a privacy bag. She said whoever admitted the resident should have changed the catheter bag to the one with a flap, or put a privacy bag on, or placed it on the other side of the bed where it would not be visible from the hallway. She said it would be a dignity issue because the resident could be embarrassed. During an interview on 05/20/2026 at 11:37 a.m., CNA E said she did not notice that the catheter bag did not have a privacy bag. She said if she noticed it when she did her rounds, she would tell the nurse about it because it should be visible from the hallway. During an interview on 05/20/2026 at 2:34 p.m., Resident #87 said the catheter was new for her and would not appreciate it if other individuals would see that she had a catheter. She said, at that point, she was still not accustomed to having a catheter, and it would embarrass her if others could see it. During an interview on 05/21/2026 at 7:20 a.m., ADON A said whoever admitted Resident #87 the night before should have made sure that the resident's catheter bag was inside a privacy bag or changed it to a catheter with a leaf. She said the other staff that were caring for her should have noticed it when they went inside the resident's room. She said the resident might be embarrassed because others could see her bag with urine. She said they would do an in-service about dignity. During an interview on 05/21/2026 at 8:16 a.m., the DON said if Resident #87 was embarrassed then it was a dignity issue that her catheter bag could be seen from the hallway. She said it should have been changed to the catheter bag that the facility was using, which was a catheter with a leaf or put the bag on the other side of the bed not visible from the hallway. She said the expectation was for the staff to provide dignity. She said she would start an (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in-service to re-educate the staff that the resident had a right to a dignified existence. During an interview on 05/21/2026 at 9:01 a.m., the Administrator-in-Training said the expectation was that the catheter bag was covered to prevent embarrassment. He said the staff could use the fig leaf urinary drain bag to keep the bag covered. He said he would coordinate with the DON about the catheter bag without a privacy bag. 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.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for two of ten residents (Resident #54 and Resident #6) reviewed for abuse and neglect.The facility failed to ensure Resident #6 was free from abuse when Resident #54 hit him on 05/05/2026. This failure could place residents at risk of abuse and emotional stress.Findings include:Record review Resident #54's face sheet revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnosis included: Hemiplegia and Hemiparesis following nontraumatic subarachnoid, Hemorrhage affecting right dominant side (a type of hemorrhagic stroke indicate damage to the brain. Because the brain's hemispheres control the opposite side of the body, right-sided motor symptoms stem from left-brain injury), Vascular dementia, severe, without behavioral disturbance (indicates advanced cognitive impairment that severely impacts independence but occurs without concurrent psychiatric or mood complications), Psychotic disturbance, mood disturbance, and anxiety (can indicate complex conditions like bipolar disorder with psychotic features, major depressive disorder with psychotic features, or severe trauma-related disorders). Record review of Resident #54's Quarterly MDS Assessment (assessment used to determine functional capabilities and health needs), dated 02/16/26, reflected the resident had a moderate cognitive impairment in cognition with a BIMS (screening tool used to assess cognitive status) score of 12. Resident #54 did indicate any Behavioral symptoms at the time assessment was completed. Record review of Resident #54's Care Plan with an initiation date of 12/18/2025 revealed Resident #54 have potential to demonstrate physical behaviors (hitting or trying to punch) r/t anger, and poor impulse control.Record review of Resident #54's Care Plan with an initiation date of 05/18/2025 revealed Resident #54 had the potential to demonstrate verbally and abusive behaviors r/t Mental / Emotional. Resident #54's Comprehensive care plan did not indicate behaviors toward staff or other residents.Record review or Resident #54's Progress notes on 05/05/2026 revealed no entries pertaining to the incident involving Resident #54 and Resident #6. Record review of Resident #6's Face Sheet revealed. revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnosis included: Secondary parkinsonism unspecified indicates symptoms are present, but the exact underlying cause is not yet determined, Bradykinesia: Slowness of movement, including difficulty initiating steps or smaller handwriting (micrographia), Rigidity: Stiffness and inflexibility in the limbs, neck, or trunk, Tremor: Shaking or trembling, often most prominent when the limbs are at rest, Neuromuscular dysfunction of bladder unspecified (the brain, spinal cord, or nerve damage interrupts signals to the bladder, resulting in symptoms like involuntary leakage, urgency, frequency, or the inability to fully empty the bladder), (The condition is a symptom or complication of an underlying neurological issue, Spinal cord injuries or diseases: Spina bifida, herniated discs, or trauma, Neurological disorders: Multiple sclerosis (MS), Parkinson's disease, or stroke). Record review of Resident #6's Quarterly MDS (tool used to assess health status) Assessment, dated 02/13/2026, reflected which indicated intact cognition with a BIMS (screening tool to assess cognitive status) score of 15. Record review of Resident #6's care plan with an initiation date of 11/11/2025 revealed Resident #6's Comprehensive Care Plan did not indicate behaviors toward staff or other residents.Record review of Resident #6's Progress notes on 05/05/2026 revealed no entries pertaining to the incident involving Resident #6 and Resident #54. Record review of the facility's grievance dated 05/05/26 revealed Care for Resident # 6, was initiated via the Ombudsman in regard to resident #54 striking Resident #6 to the DON. During an interview on 05/21/2026 at 12:45 PM the OMB stated that about two weeks ago, on 05/05/2026 she was approached by Resident #54. Where Resident #54 admitted to striking Resident #6 on the leg. The OMB stated Resident #54 I was attempting to leave the room when Resident #6 was in my way, at (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	which time I struck him in the leg Resident #6 stated during conversation that Resident #54 called Me a homosexual. I didn't bite or take his bait. The OMB stated Resident #6 stated he was okay, not hurt or had issues or concerns. The OMB stated on 05/05/2026, she informed the DON of the incident, at which point the staff took action and separated them initially and a room change was done later on same date. Record review of Texas Unified Licensure Information Portal (TULIP) on 5/21/26 at 8:25 A.M. revealed that no self-reported incidents regarding allegations of abuse were reported involving Resident #6 and Resident #54. During an interview on 05/21/2026 at 1:10 PM the DON stated during her investigation of care, [Resident #54 relayed to Ombudsman that he hit his roommate. The DON stated if there were a resident - to - resident altercation (verbally or physically), first thing would be to separate them, safety first, assess, notify the doctor and RP. The DON said if orders were given, she would follow through with the orders. The DON said, Both residents were in the W/C, and they were speaking to each and trying to maneuver around to exit the room. State Surveyor provided the DON the grievance form outlining the incident. The DON stated they would not report this incident such as the one described between Residents #54 & 6 to the state because they did a grievance. The DON felt it was not abuse. The DON stated during the time they were rooming together they never had issues with each other. The DON stated there were no other incidents of resident-to-resident altercation with Resident #54 as the perpetrator had occurred since Resident #54's incident on 05/05/26. During an interview on 05/21/2026 at 1:25 PM, State Surveyor provided the AIT the grievance form outlining the incident that occurred on 05/05/2026. The AIT confirmed he did not do an investigation into the incident involving Resident #54 striking Resident #6 on the leg. The AIT stated they would not ordinarily report an incident of abuse such as the one described with Residents #54 & #6 to the state because they did a grievance. The AIT stated they did not think it was abuse so he did not report it. During an interview on 05/21/2026 at 1:28 PM Resident #6 stated that another resident called him a homosexual and then called him the N word (racial slur) and an SOB. He stated that he wanted to hit him, but he did not. He was bipolar and things like that would make him want to react. Resident #6 stated Resident #54 kicked him in the shin; he did contact his skin, but it did not hurt nor did it leave any kind of mark. Resident #6 stated Resident #54 wanted his own room, and he thought he was doing that on purpose so they would move him. were both there and witnessed the altercation. Resident #6 stated they did move Resident #54 to another hall. Resident #6 was asked twice if he felt safe in the facility and he stated yes, both times. During an interview on 05/21/2206 at 2:02 PM SW stated she was not aware of the incident involving the two residents. Further advised in terms of a room change notification is usually a written notice and is a 5-day notice.During an interview on 05/21/2026 at 2:05 PM CNA G stated he heard yelling going on in the room and came in and immediately separated both Resident #54 & Resident #6. CNA G stated that he said he did not witness either of them hitting each other, he just heard the yelling and responded. During an interview on 05/21/2026 at 4:17 PM Resident #54 stated he did recall the incident, and he did kick him and that staff moved him to another hall. Resident #54 stated that he felt safe in the facility and that he had told the OMB what he had done.Record review of the facility Policy Abuse, Neglect and Exploitation dated revised on 12/2025 reflected:Policy: It is a policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing policies and procedures that prohibit and prevent neglect, exploitation, and misappropriation of property. IV. Identification of Abuse, Neglect and Exploitation A. The facility will have written procedures to assist staff in identifying the different types of abuse - mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This includes staff to resident abuse and certain resident to resident altercations.

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	05/21/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse, to the administrator of the facility and to other officials including to the State Survey Agency where state law provides for jurisdiction in long-term care facilities in accordance with State law through established procedures for 2 of 4 residents (Residents #54, and #6) reviewed for freedom from abuse, neglect, and exploitation.The facility failed to report an allegation of resident abuse for Resident #6 to the State Survey Agency within the allotted time frame of 2 hours, after being advised of the incident occurrence on 05/05/26 when Resident #54 admitted to striking Resident #6.These failures could put the residents at risk of abuse, allegations of abuse not being reported immediately, and could result in physical and psychosocial harm. Findings included:Record review Resident #54's face sheet revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnosis included: Hemiplegia and Hemiparesis following nontraumatic subarachnoid. Hemorrhage affecting right dominant side. (a type of hemorrhagic stroke indicate damage to the brain. Because the brain's hemispheres control the opposite side of the body, right-sided motor symptoms stem from left-brain injury). Vascular dementia, severe, without behavioral disturbance. (indicates advanced cognitive impairment that severely impacts independence but occurs without concurrent psychiatric or mood complications). Psychotic disturbance, mood disturbance, and anxiety. (can indicate complex conditions like bipolar disorder with psychotic features, major depressive disorder with psychotic features, or severe trauma-related disorders). Record review of Resident #54's Quarterly MDS Assessment (assessment used to determine functional capabilities and health needs), dated 02/16/26, reflected the resident had a moderate cognitive impairment in cognition with a BIMS (screening tool used to assess cognitive status) score of 12.Record review of Resident #54's Care Plan with an initiation date of 05/18/2025 revealed [Resident #54] Have potential to demonstrate verbally and abusive behaviors r/t Mental / Emotional. Resident #54's Comprehensive Care Plan did not indicate behaviors toward staff or other residents.Record review of Resident #54's Care Plan with an initiation date of 12/18/2025 revealed [Resident #54] Have potential to demonstrate physical behaviors (Hitting or trying to punch) r/t Anger, Poor impulse control.Record review or Resident #54's Progress notes on 05/05/2026 revealed Resident #54 was monitored for changes or symptoms. Resident #54 had no emotional distress or changes noted. Record review of Resident #6's Face Sheet revealed. revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnosis included: Secondary parkinsonism unspecified indicates symptoms are present, but the exact underlying cause is not yet determined. Bradykinesia: Slowness of movement, including difficulty initiating steps or smaller handwriting (micrographia). Rigidity: Stiffness and inflexibility in the limbs, neck, or trunk. Tremor: Shaking or trembling, often most prominent when the limbs are at rest. Neuromuscular dysfunction of bladder unspecified (The brain, spinal cord, or nerve damage interrupts signals to the bladder, resulting in symptoms like involuntary leakage, urgency, frequency, or the inability to fully empty the bladder). (The condition is a symptom or complication of an underlying neurological issue. Spinal cord injuries or diseases: Spina bifida, herniated discs, or trauma. Neurological disorders: Multiple sclerosis (MS), Parkinson's disease, or stroke). Record review of Resident #6's Quarterly MDS (tool used to assess health status) Assessment, dated 02/13/2026, reflected which indicated intact cognition with a BIMS (screening tool to assess cognitive status) score of 15. Record review of Resident #6's care plan with an initiation date of 11/11/2025 revealed [Resident #6] Resident #6's Comprehensive Care Plan did not indicate behaviors toward staff or other residents.Record review of Resident #6's Progress notes on 05/05/2026 revealed Resident #6 was monitored for changes or (continued on next page)

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	676448	A. Building B. Wing	05/21/2026

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The Reserve at Richardson	1610 Richardson Dr Richardson, TX 75080

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	symptoms. Resident #6 had no emotional distress or changes noted.Record review of the facility grievance dated 05/05/26 revealed an allegation of Resident Care for Resident # 6, was initiated via the Ombudsman in regard to both residents to the DON. Record review of Texas Unified Licensure Information Portal (TULIP) on 5/21/26 at 8:25 A.M. revealed that no self-reported incidents regarding allegations of neglect were reported for resident #6.During an interview on 05/21/2026 at 12:45 PM OMB stated that she was approached by Resident # 54, where he admitted to striking Resident #6 in the leg. OMB stated spoke with both resident's, Resident #6 stated during conversation, Resident #54 called Me a Homosexual, I didn't bite or take his bait. Resident #6 stated was okay not hurt or had issues or concerns. OMB stated advised the DON, of the incident at which point they took action and separated them initially and a Room change was done later on same date. During an interview on 05/21/2026 at DON stated during her investigation of Care, Resident relayed to Ombudsman that he hit his roommate. Interviewed were no witnesses resident is well. The DON stated if there were a Resident - to - Resident altercation (verbally or physically), first thing would be to separate them, safety first, assess, notify doctor and RP. DON said if orders were given, she would follow through with the orders. Both residents were in the W/C and they were speaking to each and trying to maneuver around to exit the room. The DON stated they would not report a grievance such as the one described between Resident #54 & 6 to the state because they did a grievance. DON felt this was not abuse. [NAME] stated during the time they were rooming together they never had issues with each other. there were no other incidents of resident-to-resident altercation with Resident #54 as the perpetrator had occurred since Resident #54's incident on 05/05/26. During an interview on 05/21/2026 at 1:25 PM, the AIT confirmed he did not do an investigation. AIT stated they would not ordinarily report a grievance such as the one described with Resident #54 & 6 to the state because they did a grievance. did not think it was abuse so I did not report it. During an interview with SW at 2:02 PM stated she was not aware of the incident involving the two residents. Further advised in terms of room change notification is usually a written notice and is a 5 day notice.During an interview on 05/21/2026 at 2:45 PM ADMIN confirmed the AIT, did not complete an investigation. Further added after looking into this perhaps this should have been reported.Record review of the facility Policy Abuse, Neglect and Exploitation dated revised on 12/2025 reflected:Policy: It is a policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing policies and procedures that prohibit and prevent neglect, exploitation, and misappropriation of property. IV. Identification of Abuse, Neglect and Exploitation A. The facility will have written procedures to assist staff in identifying the different types of abuse - mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This includes staff to resident abuse and certain resident to resident altercations. B. Possible indicators of abuse include, but are not limited to: 2. Physical marks such as bruises or patterned appearances such as a handprint, belt, or ring mark on a resident ' s body. 3. Physical injury of a resident, of unknown source. VII. Reporting/Response: The facility will have written procedures that include: Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

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	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	1610 Richardson Dr Richardson, TX 75080

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have evidence that all allegations of abuse, neglect, exploitation, or mistreatment, were thoroughly investigated for 1 of 5 residents (Resident #6) reviewed for abuse and neglect.The facility was made aware of the incident on 05/05/2026 and did not investigate an allegation of abuse which Resident #6 was struck on the leg by Resident #54. This failure could place residents at risk for abuse/neglect and could lead to a diminished quality of life and psychosocial harm.Record review Resident #54's face sheet revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnosis included: Hemiplegia and Hemiparesis following nontraumatic subarachnoid. Hemorrhage affecting right dominant side. (a type of hemorrhagic stroke indicate damage to the brain. Because the brain's hemispheres control the opposite side of the body, right-sided motor symptoms stem from left-brain injury). Vascular dementia, severe, without behavioral disturbance. (indicates advanced cognitive impairment that severely impacts independence but occurs without concurrent psychiatric or mood complications). Psychotic disturbance, mood disturbance, and anxiety. (can indicate complex conditions like bipolar disorder with psychotic features, major depressive disorder with psychotic features, or severe trauma-related disorders). Record review of Resident #54's Quarterly MDS Assessment (assessment used to determine functional capabilities and health needs), dated 02/16/26, reflected the resident had a moderate cognitive impairment in cognition with a BIMS (screening tool used to assess cognitive status) score of 12.Record review of Resident #54's Care Plan with an initiation date of 05/18/2025 revealed [Resident #54] Have potential to demonstrate verbally and abusive behaviors r/t Mental / Emotional. Resident #54's Comprehensive Care Plan did not indicate behaviors toward staff or other residents.Record review of Resident #54's Care Plan with an initiation date of 12/18/2025 revealed [Resident #54] Have potential to demonstrate physical behaviors (Hitting or trying to punch) r/t Anger, Poor impulse control. Record review or Resident #54's Progress notes on 05/05/2026 revealed Resident #54 was monitored for changes or symptoms. Resident #54 had no emotional distress or changes noted.Record review of Resident #6's Face Sheet revealed. revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnosis included: Secondary parkinsonism unspecified indicates symptoms are present, but the exact underlying cause is not yet determined. Bradykinesia: Slowness of movement, including difficulty initiating steps or smaller handwriting (micrographia). Rigidity: Stiffness and inflexibility in the limbs, neck, or trunk. Tremor: Shaking or trembling, often most prominent when the limbs are at rest. Neuromuscular dysfunction of bladder unspecified (The brain, spinal cord, or nerve damage interrupts signals to the bladder, resulting in symptoms like involuntary leakage, urgency, frequency, or the inability to fully empty the bladder). (The condition is a symptom or complication of an underlying neurological issue. Spinal cord injuries or diseases: Spina bifida, herniated discs, or trauma. Neurological disorders: Multiple sclerosis (MS), Parkinson's disease, or stroke). Record review of Resident #6's Quarterly MDS (tool used to assess health status) Assessment, dated 02/13/2026, reflected which indicated intact cognition with a BIMS (screening tool to assess cognitive status) score of 15. Record review of Resident #6's care plan with an initiation date of 11/11/2025 revealed [Resident #6] Resident #6's Comprehensive Care Plan did not indicate behaviors toward staff or other residents.Record review of Resident #6's Progress notes on 05/05/2026 revealed Resident #6 was monitored for changes or symptoms. Resident #6 had no emotional distress or changes noted.Record review of the facility grievance dated 05/05/26 revealed an allegation of Resident Care for Resident # 6, was initiated via the Ombudsman in regard to both residents to the DON. Record review of Texas Unified Licensure Information Portal (TULIP) on 5/21/26 at 8:25 A.M. revealed that no self-reported incidents regarding allegations of neglect were reported for resident #06. During an interview on 05/21/2026 at 12:45 PM OMB stated that she was approached by Resident # 54, where he admitted to striking Resident #6 in (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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the leg. OMB stated spoke with both resident's, Resident #6 stated during conversation, Resident #54 called Me a Homosexual, I didn't bite or take his bait. Resident #6 stated was okay not hurt or had issues or concerns. OMB stated advised the DON, of the incident at which point they took action and separated them initially and a Room change was done later on same date. During an interview on 05/21/2026 at DON stated during her investigation of Care, Resident relayed to Ombudsman that he hit his roommate. Interviewed were no witnesses resident is well. The DON stated if there were a Resident - to - Resident altercation (verbally or physically), first thing would be to separate them, safety first, assess, notify doctor and RP. DON said if orders were given, she would follow through with the orders. Both residents were in the W/C and they were speaking to each and trying to maneuver around to exit the room. The DON stated they would not report a grievance such as the one described between Resident #54 & 6 to the state because they did a grievance. DON felt this was not abuse. During an interview on 05/21/2026 at 1:25 PM, the (AIT) confirmed he did not do an investigation. AIT stated they would not ordinarily report a grievance such as the one described with Resident #54 & 6 to the state because they did a grievance. did not think it was abuse so he did not report it. During an interview with SW at 2:02 PM stated she was not aware of the incident involving the two residents. Further advised in terms of room change notification is usually a written notice and is a 5 day notice.During an interview on 05/21/2026 at 2:45 PM ADMIN confirmed the AIT, did not complete an investigation. Further added after looking into this perhaps this should have been reported. Record review of the facility Policy Abuse, Neglect and Exploitation dated revised on 12/2025 reflected:It is a policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing policies and procedures that prohibit and prevent neglect, exploitation, and misappropriation of property. IV. Identification of Abuse, Neglect and Exploitation A. The facility will have written procedures to assist staff in identifying the different types of abuse - mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This includes staff to resident abuse and certain resident to resident altercations. B. Possible indicators of abuse include, but are not limited to: 2. Physical marks such as bruises or patterned appearances such as a handprint, belt, or ring mark on a resident ' s body. 3. Physical injury of a resident, of unknown source. V. Investigation of Alleged Abuse, Neglect and ExploitationA. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.B. Written procedures for investigations include:I. Identifying staff responsible for the investigation;2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence);3. Investigating different types of alleged violations;4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations;5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and6. Providing complete and thorough documentation of the investigation.VII. Reporting/Response: The facility will have written procedures that include: Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

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	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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** Based on observations, interviews, and record reviews, the facility failed to ensure that the residents' environment remained free of hazards as was possible for one of eighteen residents (Resident #87) and one direct care staff (LVN B) of three direct care staff reviewed for accident hazard. 1. The facility failed to ensure CNA E did not transfer Resident #87 using a Hoyer lift (a mechanical lift used to transfer an individual with limited mobility) by herself, and leave the resident suspended in the air via the Hoyer lift without supervision on 05/20/2026. 2. The facility failed to ensure LVN B did not leave a container of germicidal wipes (substance that destroys germs and microorganism) on top of her cart unattended on 05/20/2026. These failures could place residents at risk of injuries and exposure to toxic chemicals. Findings included: 1.Record review of Resident #87's Face Sheet, dated 05/21/2026, reflected a [AGE] year-old female re-admitted to the facility on [DATE]. The resident was diagnosed with reduced mobility. Record review of Resident #87's Comprehensive MDS Assessment, dated 04/29/2026, reflected that the resident had a moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment indicated that the resident was dependent on the staff for transfer. Record review of Resident #87's Care Plan, dated 05/20/2026, reflected that the resident had an ADL self-care performance deficit and one of the interventions was to transfer via Hoyer lift. During an observation on 05/20/2026 at 8:57 a.m. revealed CNA E was about to transfer Resident #87 from the bed to the recliner via Hoyer lift. She went inside the resident's room with a Hoyer lift and asked the resident if she wanted to be transferred to her wheelchair. The resident said she wanted to be transferred to her recliner instead. CNA E rolled the resident and fixed the Hoyer sling onto the resident's back. After fixing the Hoyer sling, she hooked the loops of the Hoyer sling to the sling attachment hooks of the Hoyer lift and started to raise the resident by holding the remote control in her right hand. When the Hoyer sling with the resident was up, she started to move the Hoyer lift away from the bed towards the resident's recliner. Once the Hoyer lift was near the recliner, she spread the legs of the Hoyer lift and continued to push the Hoyer lift towards the recliner. Nobody was guiding the Hoyer sling while it was being raised and while it was pushed towards the recliner. CNA E then went out of the room, leaving the resident dangling in the air. She returned to the resident's room with LVN B, and both lowered the resident to her recliner. Once the resident was in her recliner, they unhooked the loops of the Hoyer sling from the Hoyer lift, and pulled the Hoyer lift away from the wheelchair. During an interview on 05/20/2026 at 11:21 a.m., LVN B said she told CNA E that Resident #87 wanted to be transferred to her recliner. She said she was not aware that CNA E had already prepared the resident for transfer and started the transfer. She said CNA E only called her when she was about to lower the resident. She said CNA E should have called her, or another staff member, before raising and maneuvering the lift to make sure that the transfer was safe, and no injuries would happen to the resident. She said, if she were busy, she could always ask for somebody else's assistance. During an interview on 05/20/2026 at 11:37 a.m., CNA E said she knew that transfer via Hoyer lift required two-person assistance, but she was in a rush that was why she did the transfer by herself. She said she should have called another staff member before she transferred Resident #87 to make sure the transfer was safe. She said she went out of the room to call another staff because she cannot lower the resident to the recliner without somebody assisting Resident #87. 2.During an observation on 05/20/2026 starting at 7:27 a.m. to 9:21 a.m. revealed a container of germicidal wipes was on top of LVN B's cart. It was observed that LVN B was going in and out of some residents' rooms to do treatments and was closing the doors while she was doing the treatments. LVN B would leave the container of germicidal wipes on top of her cart, unattended. At 9:21 a.m., she went inside a resident's room, turned her back from her cart, and left the lid of the container open with some wipes visibly out. It was observed that at the back of the container was a (continued on next page)

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The Reserve at Richardson	1610 Richardson Dr Richardson, TX 75080

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(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	note that said Keep out of reach of children. It was observed that several residents were passing by the cart. During an observation on 05/20/2026 at 10:48 a.m. revealed LVN B's cart was parked outside the nurses' station. The container of germicidal wipes was still on top of her cart, and the lid was still open. It was observed that nobody was inside the nurses' station. During an interview and observation on 05/20/2026 at 11:21 a.m., LVN B said she used the germicidal wipes to sanitize the bp cuff and the glucometer that she was using. She said she forgot to put the container of germicidal wipes inside the drawer of her cart when she went inside a residents' room. She said she should have placed the germicidal wipes inside the cart before he closed the door to give medications because residents might be able to get hold of the wipes and use them to clean their faces and eyes that could result in irritations. She said some residents were confused and might go inside the rooms of other residents. She took the container of germicidal wipes and put it inside the last drawer of the cart she was using. She said there they had a population that would wander around the facility. During an interview on 05/21/2026 at 7:20 a.m., ADON A said transfer via Hoyer lift should be done by two staff to ensure resident safety and better control of the lift's movement. She said improper technique could lead to falls and injuries. She said she should have called another staff member before raising the Hoyer lift. She said the container of disinfectant, closed or opened, should have been placed inside the cart when staff were leaving their cart. She said residents could get some and use them on their face and body. She said the wipes could cause irritation, that was why the staff were using gloves everytime they used the wipes. She said the expectation was that transfer via Hoyer lift would always be done by two staff members to ensure safety. She said another expectation was for the staff not to leave the germicidal wipes within reach of the residents. She said they would start an in-service about Hoyer transfer and storage of germicidal wipes. During an interview on 05/21/2026 at 8:16 a.m., the DON said staff could not transfer a resident via Hoyer lift by themselves because it was dangerous. She said a one-person transfer via Hoyer lift could present safety issues to the resident and to the staff as well. She said the resident might fall that could result in injuries, or the machine could tilt to one side and fall on the staff. She said the germicidal wipes should not be left unattended because the residents might get hold of the wipes and use them to clean their eyes. She said the expectation was for all the staff to follow their policy about transferring via Hoyer lift and not to leave the germicidal wipes unattended. She said she would start an in-service to re-educate the staff about proper transfer, and the harm germicidal wipes could cause. During an interview on 05/21/2026 at 9:01 a.m., the Administrator-in-Training said the expectation was that two staff would transfer residents using Hoyer lift because it was dangerous and the residents could be seriously injured. He said another expectation was to store the germicidal wipes accordingly before walking away from their carts to ensure that residents would not be able to get any. He said he would coordinate with the DON about the transfer and the germicidal wipes. Record review of the facility's policy Lifting Machine, Using a Mechanical reviewed December 2025 reflected Purpose: The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device . General Guidelines . 1. At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. 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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	676448	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	1610 Richardson Dr Richardson, TX 75080

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(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** 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 for two of five residents (Resident #3 and Resident #87) reviewed for incontinent care. 1. The facility failed to ensure Resident #3's catheter bag was off the floor on 05/19/2026. 2. The facility failed to ensure that CNA E did not place Resident #87's catheter bag on top of the resident's bed, rendering the catheter to not be below the bladder while changing the resident's clothing on 05/20/2026. 3. The facility failed to ensure Resident #87's catheter bag was off the floor on 05/20/2026. These failures could place the residents at risk for urinary tract infection. Findings included: 1.Record review of Resident #3's Face Sheet, dated 05/21/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with neuromuscular dysfunction of the bladder. Record review of Resident #3's Comprehensive MDS Assessment, dated 04/29/2026, reflected that the resident had a severe impairment (resident required significant assistance and support in daily life) in cognition with a BIMS score of 05. The Comprehensive MDS Assessment indicated that the resident had an indwelling catheter. Record review of Resident #3's Comprehensive Care Plan, dated 04/07/2026, reflected that the resident had a suprapubic catheter (device inserted into the stomach to the bladder to drain urine) and one of the interventions was to change catheter bag when closed system was compromised. Record review of Resident #3's Physician Order, dated 01/15/2026, reflected SPC 16F (French: unit of measurement for catheter sizes) with 10_ml balloon DX for Suprapubic catheter use: Neurogenic Bladder (the normal bladder function is disrupted due to nerve damage). During an observation on 05/19/2026 at 11:41 a.m., revealed Resident #3 was in her bed with eyes closed, her catheter bag was hanging on the bed railing and was touching the floor. During an observation and interview on 05/19/2026 at 11:44 a.m., LVN C said the catheter bag should be off the floor because it could result in urinary tract infection. She went inside Resident #3's room and saw that the resident's catheter bag was touching the floor. She said, maybe, somebody changed and put the bed in the lowest position but did not notice that the bag was touching the floor. She raised the resident's bed until the catheter bag was off the floor. She said she would talk to CNA F, who was assigned to the resident, to remind her that catheter bags should not be touching the floor. She said she would also change the resident's catheter bag. During an interview on 05/19/2026 at 11:47 a.m., CNA F said she was not the one who changed Resident #3 and left the room with the catheter bag on the floor. She said the catheter bag should not be touching the floor because it could result in urinary tract infection. 2.Record review of Resident #87's Face Sheet, dated 05/21/2026, reflected a [AGE] year-old female re-admitted to the facility on [DATE]. The resident was diagnosed with neuromuscular dysfunction of the bladder. Record review of Resident #87's Comprehensive MDS Assessment, dated 04/29/2026, reflected that the resident had a moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment indicated that the resident had an indwelling catheter. Record review of Resident #87's Comprehensive Care Plan, dated 05/20/2026, reflected that the resident had an indwelling catheter and one of the interventions was to provide catheter care. Record review of Resident #87's Physician Order, dated 05/19/2026, reflected Keep urinary drainage bag below the level of the bladder at all times every shift related to NEUROMUSCULAR DYSFUNCTION OF BLADDER, UNSPECIFIED. During an observation on 05/20/2026 at 8:39 a.m., CNA F changed Resident #87's clothing, she placed the resident's catheter bag on top of the bed, where it remained. It was observed that there was urine was in the catheter tubing. During an interview on 05/20/2026 at 11:21 a.m., LVN B said the catheter bag should not be placed on top of the bed and should always be below the bladder to prevent urine from flowing back to the bladder that could result in infection. During an interview on 05/20/2026 at 11:37 a.m., CNA F said (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she put on Resident #87's pants, that was why she placed the catheter on top of the bed. She said she should have placed the catheter bag back to the railing as soon as she slipped the catheter bag in one of the legs of the resident's pants. She said it did not occur to her that urine could go back inside the resident's body and could cause infection. She said the facility provided check-offs with regards to catheter care but did not pay attention. 3.During an observation on 05/20/2026 at 9:43 a.m., Resident #87 was sitting in her recliner, her catheter bag was on the floor. During an observation and interview on 05/20/2026 at 9:44 a.m., LVN B said the catheter should have been secured to prevent it from falling to the floor. She said microorganisms could creep inside the catheter to the bladder causing urinary tract infection. She said she would also change the catheter bag. During an interview on 05/20/2026 at 11:37 a.m., CNA F said the catheter bag kept falling, that was why she just left it on the floor and forget to tell the nurse about it. She said the floor was dirty, making the catheter bag dirtier. During an interview on 05/21/2026 at 7:20 a.m., ADON A said the catheter bag should always be below the bladder to prevent urine from going back to the bladder that could eventually cause a urinary tract infection. She said the staff could hang the catheter bag on the other side if they needed to turn the resident. She said catheter bags should be off the floor because it could also cause UTI. She said the expectations were for catheter bags would always be below the bladder and off the floor. She said they started an in-service about catheter care. During an interview on 05/21/2026 at 8:16 a.m., the DON said the catheter bags should always be below the bladder to prevent backflow of urine from the catheter bag to the bladder. She said if there was a backflow, it could result in urinary tract infection. She said the staff should have hung the catheter again after putting the resident's pants on. She said the bags should not be touching the floor to keep it clean and prevent UTI. She said she would start an in-service to re-educate the staff about catheter care. During an interview on 05/21/2026 at 9:01 a.m., the Administrator-in-Training said the expectation was that the catheter bag always be below the bladder and off the floor to prevent infection. He said he would coordinate with the DON about the catheter. Record review of the facility's policy Catheter Care, Urinary Catheter Care P & P revised June 18, 2018, reflected Purpose: The purpose of this procedure is to prevent catheter-associated urinary tract infections . Input/Output . Maintaining Unobstructed Urine Flow . 3. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder . Infection Control . Maintain clean technique . b. Be sure the catheter tubing and drainage bag are kept off the floor.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide appropriate treatment and services to prevent complications of enteral feeding for one of four residents (Resident #85) reviewed for feeding tube management. The facility failed to ensure LVN B checked Resident #85's gastric residual and g-tube placement before flushing and administering medications on 05/20/2026. This failure could place residents with g-tubes at risk for tube displacement, clogging, aspiration, and discomfort.Findings included: Record review of Resident #85's Face Sheet, dated 05/21/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with gastrostomy status (having done a surgical procedure that creates artificial opening into the stomach to provide nutritional support). Record review of Resident #85's Comprehensive MDS Assessment, dated 05/15/2026, reflected that the resident had severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident had a feeding tube (a way of providing nutrition directly to the stomach). Record review of Resident #85's Quarterly Care Plan, dated 04/15/2026, reflected that the resident required tube feeding and one of the interventions was to check for gastric residual (food, liquid, and secretions remaining in the stomach) and tube placement. Record review of Resident #85's Physician Order, dated 05/18/2026, reflected every shift for Tube Feeding Orders (JEVITY 1.5 @ 35ML/HR H20 FLUSH 35 ML/HR (USE WATER PROVIDED BY FAMILY) run 22 hours and 2 hours down time for ADL's. Record review of Resident #85's Physician Order, dated 05/14/2026, reflected every shift Auscultate (listening to the sounds inside the body using a stethoscope) for Tube Placement before feeding and medication administration Q Shift and PRN related to GASTROSTOMY STATUS. Record review of Resident #85's Physician Order, dated 05/14/2026, reflected every shift Check Residual prior to feeding if greater than 150 cc return contents and HOLD feeding and notify MD related to GASTROSTOMY STATUS. During an observation on 05/20/2026 at 9:06 a.m., LVN B turned off Resident #8's feeding machine and disconnected the g-tube from the formula. After disconnecting the g-tube, she took the syringe from the overbed table and flushed the g-tube with 30 cc of water, gave the medications one by one flushing between each medication. LVN B did not check for gastric residual or placement of the g-tube prior to administering the medications. During an interview on 05/20/2026 at 11:21 a.m., LVN B said she should check for residual before medication administration to assess if the resident's stomach was emptying well. She said if the stomach was not emptying well, adding liquid could result in aspiration or vomiting. She said the resident was on continuous feeding; that was why she did not check for the residual. She said she should also check the placement of the g-tube before medication administration to ensure the tube was not dislodged. During an interview on 05/21/2026 at 7:20 a.m., ADON A said g-tube placement and gastric residual should be checked before introducing water and administering medications. She said g-tube placement should be checked to ensure the g-tube was in the right place and would not cause aspiration. She said even though the residents were on continuous feeding, the placement should still be checked to see if the stomach could accommodate additional water and the medications. She said checking for the residual was also one way to assess if the stomach was emptying. She said not checking the residual might cause vomiting and aspiration pneumonia (food going inside the lungs). She said the expectation was for the staff to check for g-tube placement and the gastric residuals before flushing and administering medications. She said they would start an in-service about checking g-tube placement and residual checks. During an interview on 05/21/2026 at 8:16 a.m., the DON said the placement of the g-tube should be checked before flushing the g-tube and before medication administration to ensure the medications and the fluid would enter the stomach. He said checking the placement was a safety step to ensure the tube was not in other parts of the body, like the lungs, esophagus, and cavities inside the body, that could result in aspiration and (continued on next page)

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	676448	A. Building B. Wing	05/21/2026

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ineffective feeding because the formula was not delivered to the intended site. She said gastric contents should also be checked, regardless of whether the mode of feeding was bolus or continuous, to ensure there was no delayed emptying of the stomach. She said the expectation was for the staff to follow the policies and procedures for enteral feeding. She said she would start an in-service to re-educate the staff about checking g-tube placement and the gastric residuals. During an interview on 05/21/2026 at 9:01 a.m., the Administrator-in-Training said the expectation was for the staff to check g-tube placement and the residual content as per orders. He said he would coordinate with the DON about g-tube. Record review of the facility's policy Enteral Nutrition (delivery of food through feeding tube) reviewed December 2025 reflected Policy Statement: Adequate nutritional support through enteral feeding will be provided to residents as ordered . Policy Interpretation and Implementation . 12. Staff caring for the residents with feeding tube will be trained on potential adverse effects . d. feeding tube associated complications . 13. Staff . will be trained . e. Clogging of the tube . 15. Risk of aspiration will be assessed . may be affected by . d. Failure to confirm placement of the feeding tube.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **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 was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two of ten residents (Residents #46 and Resident #87) reviewed for respiratory care. 1.The facility failed to ensure Resident #46's nasal cannula was stored properly when not in use on 05/21/2026.2.The facility failed to ensure Resident #87's nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) was stored properly when not in use on 05/20/2026. These failures could place residents at risk for respiratory infection and not having their respiratory needs met.Findings included: 1.Record review of Resident #46's Face Sheet, dated 05/21/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with shortness of breath. Record review of Resident #46's Comprehensive MDS Assessment, dated 05/02/2026, reflected the resident was cognitively intact (resident may need additional support and monitoring) with a BIMS score of 14. The Comprehensive MDS Assessment indicated the resident had shortness of breath and was on oxygen therapy. Record review of Resident #46's Care Plan, dated 05/06/2026, reflected the resident had shortness of breath and one of the interventions was to administer oxygen as needed. Record review of Resident #46's Physician Order, dated 04/28/2026, 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. During an observation and interview on 05/20/2026 at 9:28 a.m., Resident #46 was in his chair, his nasal cannula was on top of his bed. Resident #46 said he would use oxygen occasionally, he said he went to therapy without oxygen. He said nobody told him to put his nasal cannula inside a bag and he did not have a bag for his nasal cannula. 2.Record review of Resident #87's Face Sheet, dated 05/21/2026, reflected a [AGE] year-old female re-admitted to the facility on [DATE]. The resident was diagnosed with shortness of breath. Record review of Resident #87's Comprehensive MDS Assessment, dated 04/29/2026, reflected the resident had a moderate impairment in cognition with a BIMS score of 12 (resident may need additional support and monitoring). The Comprehensive MDS Assessment indicated the resident had shortness of breath and was on oxygen therapy. Record review of Resident #87's Care Plan, dated 05/20/2026, reflected the resident had shortness of breath and one of the interventions was to administer oxygen as needed. Record review of Resident #87's Physician Order, dated 05/19/2026, reflected OXYGEN @ __2-4_____ lpm via N/C OR FACE MASK TO MAINTAIN O2 SATS GREATER THAN 90% FOR SOB PRN every 8 hours as needed for SOB, O2Sats. During an observation and interview on 05/20/2026 at 8:35 a.m., revealed Resident #87 was in her bed, awake, her nasal cannula was unbagged on top of the oxygen concentrator. She said she did not use her oxygen always. During an observation and interview on 05/20/2026 at 11:21 a.m., LVN B said the nasal cannula should be bagged to prevent any respiratory infection. She went inside Resident #46 and Resident #87's rooms, disconnected the nasal cannula, and threw them in the trash can. She said she did not notice the nasal cannulas was not bagged. She said for Resident #46, sometimes he would take it off or staff would take it off. She said she should educate Resident #46 to bag his nasal cannula if he takes it off. During an interview on 05/21/2026 at 7:20 a.m., ADON A said the nasal canula should be bagged when not in use to prevent any respiratory infection. She said sometimes, Resident #46 was the one who would take it off, so the staff should closely monitor the resident. She said they would do an in-service about respiratory care. During an interview on 05/21/2026 at 8:16 a.m., the DON said the staff was responsible in making sure the nasal cannula was bagged when not in use to prevent respiratory infection. She said the expectation was for the staff to bag the nasal cannula when not in use. She said she would start an in-service about respiratory care and would include the rehabilitation department because sometimes they would get the residents to go for therapy, and they were the ones taking the nasal canula off. During an (continued on next page)

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	676448	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Reserve at Richardson	1610 Richardson Dr Richardson, TX 75080

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 05/21/2026 at 9:01 a.m., the Administrator-in-Training said the expectation was for the staff to bag the nasal cannula when not in use to prevent respiratory issues. He said he would coordinate with the DON about the issue. Record review of facility's policy, Respiratory Therapy revised November 2011 reflected 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for one of ten residents (Resident #67) reviewed for pharmaceutical services. The facility failed to dispose of Resident #67's expired insulin on 05/21/2026. This failure could place residents at risk of not receiving the medication's full therapeutic benefits and not receiving medications as ordered resulting to adverse effects.Findings included: Record review of Resident #67's Face Sheet, dated 05/21/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus (high blood sugar). Record review of Resident #67's Comprehensive MDS Assessment, dated 04/01/2026, reflected that the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had diabetes mellitus and was receiving insulin. Record review of Resident #67's Comprehensive Care Plan, dated 04/21/2026, reflected the resident had diabetes mellitus and one of the interventions was to administer diabetes medication as ordered. Record review of Resident #67's Physician Order, dated 02/03/2026, reflected NovoLog Injection Solution 100 UNIT/ML (Insulin Aspart) Inject subcutaneously (administer under the skin) two times a day for DM2. During an observation on 05/21/2026 at 12:01 p.m., revealed Resident #67's insulin KwikPen was inside a nurse's cart with an open date of 04/10/2026. During an observation and interview on 05/21/2026 at 12:02 p.m., LVN C said Resident #67's insulin was already expired because it was past twenty-eight days from its opening date. She said after 28 days, the insulin was already considered expired. She said the insulin should have been disposed of on 05/08/2026. She took the insulin and discarded it. She said it was an oversight on her part because she did not check the expiration date of the resident's insulin. She said expired medications could be less effective or more toxic. During an interview on 05/21/2026 at 7:20 a.m., ADON A said there should not be expired medication inside the carts because expired medications could be less potent and would not be able to provide the full benefit of the medications. She said the nurses administering the insulin were responsible for ensuring the insulin was not expired. She said most of the insulin had a shelf life of twenty-eight days and beyond that the insulin was already considered expired. She said the expectation was that the staff would check the carts for expired medications. She said they would start an in-service about expired medications. During an interview on 05/21/2026 at 8:16 a.m., the DON said the expired insulin should have been disposed after twenty-eight because it had already expired and could be less potent. She said the nurses were responsible for checking their carts for expired medications. She said she would start an in-service to remind the staff to always check the carts for expired medications. During an interview on 05/21/2026 at 9:01 a.m., the Administrator-in-Training said the expectation was for the staff to check for the expiration date of any medications before administering them to prevent any adverse reactions. He said he would coordinate with the DON regarding the expired medication. Record review of the facility's policy Administering Oral Medications reviewed December 2025 reflected Purpose: The purpose of this procedure is to provide guidelines for the safe administration of oral medications . Steps in the Procedure . Check the expiration date on the medication.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, in accordance with accepted professional standards and practices, the facility failed to maintain medical records on each resident that are complete; accurately documented; readily accessible; and systematically organized for for 2 (Resident #20 and Resident #66) of 5 residents reviewed for Advanced Directives. The facility failed to ensure that Resident #20 and Resident #66's OOH-DNR (Out of Hospital-Do Not Resuscitate) were completed correctly with both signatures not meeting the criteria for a qualified witness, making the forms invalid. This failure could affect all residents who have implemented an Advanced Directive and established their choice not to be resuscitated at the risk of receiving CPR (Cardiopulmonary Resuscitation) against their wishes.Findings included: Record review of Resident #20's face sheet dated [DATE] reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnosis included unspecified dementia, (a clear cognitive decline consistent with dementia but cannot identify the specific type), senile degeneration of the brain, (the progressive loss of brain cells and cognitive function associated with advanced aging), anxiety disorder and chronic kidney disease. Record review of Resident #20's quarterly MDS dated [DATE] reflected a BIMS score of 00, indicating severe cognitive impairment. Resident #20 needed maximum assistance with toileting, showering self, upper and lower body dressing and personal hygiene. Record review of Resident #20's undated care plan reflected, Focus: I am a DNR, Date initiated: [DATE]. Goal: My wishes will be honored through next review, date initiated: [DATE], Revised on [DATE]. Interventions: If found absent of vital signs, do not initiate CPR, keep my family and physician updated on my condition, date initialed, [DATE]. Record review of Resident #20's DNR dated [DATE] reflected it had been signed by a qualified relative, an adult child. The two witnesses who signed were also family members. In an interview on [DATE] at 3:12 p.m., the qualified relative stated that both witnesses were family members related to Resident #20. Record review of the Out- Of -Hospital Do-Not-Resuscitate order from the Texas Department of State Health Services reflected the following: Definitions: Qualified Witnesses: Both witnesses must be competent adults,2) one of the witnesses may not be related to the person by blood or marriage. Record review of Resident # 66's face sheet dated [DATE] reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnosis included rhabdomyolysis (a breakdown of muscle tissue that leads to the release of muscle fiber into the blood), hypertension (high blood pressure), and acute kidney failure. Record review of Resident #66's admission MDS dated [DATE] reflected a BIMS of 15 indicating cognitively intact. Resident # 66 needed moderate assistance with toileting hygiene, upper body dressing and personal hygiene and maximum assistance with showering or bathing self and lower body dressing. Record review of the undated care plan reflected, Focus: I am a DNR, Date initiated: [DATE]. Goal: My wishes will be honored through next review, date initiated: [DATE], Interventions: If found absent of vital signs, do not initiate CPR, keep my family and physician updated on my condition, date initialed, [DATE]. Record review of Resident #66's OOH-DNR dated [DATE] reflected it had been signed by the facility's AIT and the facility Social Worker. Record review of the Out- Of -Hospital Do-Not-Resuscitate order from the Texas Department of State Health Services reflected the following: Definitions: Qualified Witnesses: Both witnesses must be competent adults, 7) may not be an employee of a health care facility, an officer, director or business office employee of the health care facility. In an interview on [DATE] at 4:44 p.m., the DON stated residents are a full code until the DNR is completed, the social worker checks them for accuracy before they are uploaded to the medical record. She stated the risk to the resident was that staff could follow the wrong directive. In an interview on [DATE] at 5:10 p.m., the Administrator stated that staff are not allowed to sign the DNR's and the risk could be an adverse outcome. The facility did not have a policy regarding the OOH-DNR's.