| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455627 | A. Building<br>B. Wing | 11/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Denton Village by Purehealth | 2500 Hinkle Dr<br>Denton, TX 76201 |

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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | | |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to ensure the resident had the right to be free from neglect as defined in this subpart for one (Resident #1) of six residents reviewed for neglect. 1. On [DATE] LVN B failed to notify Resident #1's doctor or hospice provider after she checked Resident #1's BS level of 576; and on [DATE] and [DATE] LVN B failed to notify Resident #1's doctor or hospice provider after she checked Resident #1's BS levels over 600. 2. On [DATE] and [DATE] the facility failed to ensure Resident #1 was given his dayshift dose of his diabetic Metformin medications to prevent his BS level from getting higher and on [DATE] the facility failed to ensure Resident #1 received his dayshift dose of his potassium chloride medication. (There was no evidence provided that the facility contacted the pharmacy, doctor, hospice or obtained the medications from the E-kit or checked Resident #1's BS Levels). 3. On [DATE] RN A failed to check Resident #1's BS after Resident #1 fell to the floor and injured his head, it was unknown what his BS level was. Subsequently, Resident #1 was sent to the hospital [DATE] and was admitted for having a ground level fall, SAH (Subarachnoid hemorrhage- (Brain bleed), hypotension (low blood pressure) and BS level of 812 (very high). On [DATE] Resident #1 passed away. An Immediate Jeopardy (IJ) was identified on [DATE]. An IJ Template was provided to the facility on [DATE] at 5:00 pm. While the Immediate Jeopardy was removed on [DATE] at 5:57 pm, the facility remained out of compliance at a scope of pattern with a severity level of no actual harm with the potential for more than minimal harm that was not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. These failures could place all diabetic residents at risk of not getting their medications which could cause increased BS levels to be untreated and result in nerve damage, eye disease, diabetic coma, or death. Findings included: Record review of Resident #1's Hospice Patient Fact report dated [DATE] revealed, Metformin ER 500 extended release 24 hr start date [DATE] (no end date). 500 mg take 1 tab by mouth twice daily at breakfast and dinner oral. Insulin glargine, human recombinant analog U-100 insulin 100 start date [DATE] (no end date). 100 unit/ml (3 ml) inject 6 units subcutaneous at dinnertime once a day subcutaneous. Reason for medication: Diabetes. Record review of Resident #1's admission MDS assessment dated [DATE] revealed an [AGE] year-old male who admitted [DATE] from home, had a BIMS score of 00 (Severe cognitive impairment) and active diagnoses that included debility and cardiorespiratory conditions. His diagnoses were heart failure, peripheral vascular disease (circulation disorder), renal insufficiency (Poor kidney function), acute chronic systolic (congestive) heart failure. He had repeated falls, and a cognitive communication deficit. He had no pain issues but had a fall in the last 2-6 months prior to admission and had a swallowing disorder. His weight was 155 pounds and was on a mechanically altered diet. He received five insulin injections in the past seven days, oxygen therapy and hospice care. Resident #1 had an overall goal for discharge and was established to return to the community with family. (He had no diabetic or seizure diagnoses). Record review of Resident #1's Care Plan dated [DATE] revealed he had a cognitive communication deficit, acute on chronic systolic (congestive) heart failure, stage 3 chronic kidney disease (Kidney function loss), peripheral vascular disease, risk for falls - repeated falls. On [DATE] he had a urinary tract infection, terminal prognosis, and was under hospice care. Further review revealed there was no care plan related to diabetes. Record review of Resident #1's [DATE] Physician's Orders dated [DATE] by Doctor F revealed, Insulin subcutaneous solution 100 unit/ml inject 8 unit subcutaneously at bedtime for diabetes (start [DATE] - stop [DATE]). Metformin oral tablet give 500 mg by mouth two times a day for diabetes (start [DATE] - stop [DATE]). Potassium Chloride extend release 10 MEQ give 1 tablet by mouth one time a day for potassium replacement (start [DATE]- [DATE]). (There was no physicians order to check his BS twice per day as Doctor ordered by NP Q). Record review of Resident #1's [DATE] MAR dated on [DATE] by MA I revealed, his 10 MEQ potassium chloride Extended release was not given and coded 9 other/see progress notes. On [DATE] and [DATE] his 500 mg metformin was not given and coded 9 other/see progress notes. Record review of Resident #1's Vitals Section for blood sugar dated [DATE] at 9:12 am by RN A revealed his BS level was 212. Further review revealed there was no other BS level readings in this section. Record review of Resident #1's Nurses note dated [DATE] at 7:31 pm by LVN B revealed, Insulin subcutaneous solution 100 unit/ml - inject 8 units subcutaneously at bedtime for diabetes. BS 576!! Further review revealed no documented evidence his doctor or hospice provider was notified of Resident #1's BS level. Record review of Resident #1's Nurses note dated [DATE] at 8:52 pm by |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>(continued on next page) |

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|---|---|
| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure each assessment accurately reflected the resident's status and for each individual who completed a portion of the assessment must sign and certify the accuracy of that portion of the assessment for one (Resident #1) of six residents reviewed for accuracy of assessments. The facility failed to ensure Resident #1's admission MDS Assessments was complete and accurate. Resident #1 was a diabetic who took diabetic medications and he had no diabetes diagnosis listed on this assessment. This failure could place all residents at risk of inadequate care if all of their diagnoses were not included in the residents' records, which could result in a decline in the residents' health and psych-social well-being. Findings included: Record review of Resident #1's admission MDS assessment dated [DATE] revealed an [AGE] year-old male who admitted [DATE] from home, had a BIMS score of 00 (Severe cognitive impairment) and active diagnoses that included debility and cardiorespiratory conditions. His diagnoses were heart failure, peripheral vascular disease (circulation disorder), renal insufficiency (Poor kidney function), acute chronic systolic (congestive) heart failure. He had repeated falls, and a cognitive communication deficit. He had no pain issues but had a fall in the last 2-6 months prior to admission and had a swallowing disorder. His weight was 155 pounds and was on a mechanically altered diet. He received five insulin injections in the past seven days, oxygen therapy and hospice care. Resident #1 had an overall goal for discharge and was established to return to the community with family. (He had no diabetic or seizure diagnoses). Record review of Resident #1's Hospice Patient Fact report dated 10/17/25 revealed, Metformin ER 500 extended release 24 hr start date 04/25/25 (no end date). 500 mg take 1 tab by mouth twice daily at breakfast and dinner oral. Insulin glargine, human recombinant analog U-100 insulin 100 start date 07/16/25 (no end date). 100 unit/ml (3 ml) inject 6 units subcutaneous at dinnertime once a day subcutaneous. Reason for medication: Diabetes. Record review of Resident #1's Care Plan dated 10/23/25 revealed he had a cognitive communication deficit, acute on chronic systolic (congestive) heart failure, stage 3 chronic kidney disease (Kidney function loss), peripheral vascular disease, risk for falls - repeated falls. On 10/24/25 he had a urinary tract infection, terminal prognosis, and was under hospice care. Further review revealed there was no care plan related to diabetes. Record review of Resident #1's October 2025 Physician's Orders dated 10/23/25 by Doctor F revealed, Insulin subcutaneous solution 100 unit/ml inject 8 unit subcutaneously at bedtime for diabetes (start 10/23/25 - stop 10/29/25). Metformin oral tablet give 500 mg by mouth two times a day for diabetes (start 10/23/25 - stop 10/29/25). Record review of Resident #1's October 2025 MAR revealed, Insulin Subcutaneous solution 100 unit/ml inject 8 unit subcutaneous at bedtime for diabetes and Metformin oral tablet 500 mg give 500 mg by mouth two times per day for diabetes (start 10/23/25 -10/29/25). Record review of Resident #1's October 2025 MAR dated on 10/27/25 by MA I revealed, his 10 MEQ potassium chloride Extended release was not given and coded 9 other/see progress notes. On 10/27/25 and 10/28/25 his 500 mg metformin was not given and coded 9 other/see progress notes. Record review of Resident #1's Vitals Section for blood sugar dated 10/23/25 at 9:12 am by RN A revealed his BS level was 212. Further review revealed there was no other BS level readings in this section. Interviews on 11/18/25 at 4:20 pm, ADON Z stated the Regional MDS Coordinator K was responsible for completing the MDS assessments. Interview on 11/18/25 at 4:46 pm, Regional MDS Coordinator K stated he was the Corporate MDS Coordinator and the former facility MDS Coordinator stopped working at this facility last month [October 2025]. He stated he was not aware of Resident #1's MDS Assessment was inaccurate. He stated his role was to review the residents' documentation that reflected what the staff were documenting. He stated the IDT was responsible for reviewing and ensuring the residents' records were accurate and complete, but the MDS Coordinator was responsible for ensuring the MDS assessments were accurate. He stated the DON reinforced that leadership had all the information for the residents and to report any issues that they needed to address. He stated he did not want to say what could happen to a resident if their medical records were not accurate and complete. Interview on 11/18/25 at 5:07 pm, the DON stated the MDS Coordinator was responsible for ensuring all the residents' diagnoses were on their MDS Assessments. He stated he was not sure how that was missed and said not having all of the residents' diagnoses could cause a resident to get improper care or lack of care, which could run into several complications as the end result. Interview on 11/18/25 at 5:46 pm, the Administrator stated she was not sure why Resident #1's diagnoses were not on his MDS Assessment because she was not a nurse to have been able to say that |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>(continued on next page) |

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|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to, in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that were complete and accurately documented for one (Resident #1) of six residents reviewed for medical records. The facility failed to ensure Resident #1's face sheet and care plans were complete and accurate. Resident #1 was diagnosed with diabetes and took diabetic medications and he had no diabetes diagnosis on his facility's EMR records. This failure could place all residents at risk of inadequate care if all of their diagnoses were not included in the resident's EMR records, which could result in a decline in the resident's health and psych-social well-being. Findings included: Record review of Resident #1's Face Sheet dated 11/14/25 revealed an [AGE] year-old male who admitted [DATE] with diagnoses of Acute on chronic systolic (Congestive) heart failure, Peripheral vascular disease, stage 3 chronic kidney disease, repeated falls, and cognitive communicative deficit. (There was no diabetic diagnosis). Record review of Resident #1's Hospice Patient Fact report dated 10/17/25 revealed, Metformin ER 500 extended release 24 hr start date 04/25/25 (no end date). 500 mg take 1 tab by mouth twice daily at breakfast and dinner oral. Insulin glargine, human recombinant analog U-100 insulin 100 start date 07/16/25 (no end date). 100 unit/ml (3 ml) inject 6 units subcutaneous at dinnertime once a day subcutaneous. Reason for medication: Diabetes. Record review of Resident #1's admission MDS assessment dated [DATE] revealed an [AGE] year-old male who admitted [DATE] from home, had a BIMS score of 00 (Severe cognitive impairment) and active diagnoses that included debility and cardiorespiratory conditions. His diagnoses were heart failure, peripheral vascular disease (circulation disorder), renal insufficiency (Poor kidney function), acute chronic systolic (congestive) heart failure. He had repeated falls, and a cognitive communication deficit. He had no pain issues but had a fall in the last 2-6 months prior to admission and had a swallowing disorder. His weight was 155 pounds and was on a mechanically altered diet. He received five insulin injections in the past seven days, oxygen therapy and hospice care. Resident #1 had an overall goal for discharge and was established to return to the community with family. (He had no diabetic diagnosis). Record review of Resident #1's Care Plan dated 10/23/25 revealed he had a cognitive communication deficit, acute on chronic systolic (congestive) heart failure, stage 3 chronic kidney disease (Kidney function loss), peripheral vascular disease, risk for falls - repeated falls. On 10/24/25 he had a urinary tract infection, terminal prognosis, and was under hospice care. Further review revealed there was no care plan related to diabetes. Record review of Resident #1's October 2025 Physician's Orders dated 10/23/25 by Doctor F revealed, Insulin subcutaneous solution 100 unit/ml inject 8 unit subcutaneously at bedtime for diabetes (start 10/23/25 - stop 10/29/25). Metformin oral tablet give 500 mg by mouth two times a day for diabetes (start 10/23/25 - stop 10/29/25). Record review of Resident #1's October 2025 MAR revealed, Insulin Subcutaneous solution 100 unit/ml inject 8 unit subcutaneous at bedtime for diabetes and Metformin oral tablet 500 mg give 500 mg by mouth two times per day for diabetes (start 10/23/25 -10/29/25). Record review of Resident #1's Vitals Section for blood sugar dated 10/23/25 at 9:12 am by RN A revealed his BS level was 212. Further review revealed there was no other BS level readings in this section. Interviews on 11/18/25 at 4:20 pm, ADON Z stated the Admissions Director completed the resident's face sheets and the Regional MDS Coordinator K was responsible for completing the care plans. Interview on 11/18/25 at 4:46 pm, Regional MDS Coordinator K stated he was the Corporate MDS Coordinator and the former facility MDS Coordinator stopped working at this facility last month [October 2025]. He stated he was not aware of Resident #1's face sheets and Care Plans were inaccurate. He stated his role was to review the residents' documentation that reflected what the staff were documenting. He stated the IDT was responsible for reviewing and ensuring the residents' records were accurate and complete, He stated the DON reinforced that leadership had all the information for the residents and to report any issues that they needed to address. He stated he did not want to say what could happen to a resident if their medical records were not accurate and complete. Interview on 11/18/25 at 5:07 pm, the DON stated the MDS Coordinator was responsible for ensuring all the residents' diagnoses were on their face sheets. He stated he was not sure how that was missed and said not having all of the residents' diagnoses could cause a resident to get improper care or lack of care, which could run into several complications as the end result. Interview on 11/18/25 at 5:46 pm, the Administrator stated she was not sure why Resident #1's diagnoses were not on his face sheet and care plan because she was not a nurse to have been able to say that was missing. She stated the clinical |