STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455627	A. Building B. Wing	09/19/2025

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

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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 - Some	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 with bladder received appropriate treatment and services to prevent urinary tract infection for three (Resident #8, Resident #15, and Resident #21) of three residents reviewed for incontinent care. 1. The facility failed to ensure that CNA F performed the right technique during Resident #8's incontinent care on 09/18/2025. 2. The facility failed to ensure that CNA F performed the right technique during Resident #15's incontinent care on 09/18/2025. 3. The facility failed to ensure that CNA E performed the right technique during resident #21's incontinent care on 09/18/2025. This failure could place residents at risk for urinary tract infection. Findings included: 1. Record review of Resident #8's Face Sheet, dated 09/18/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with cystitis (inflammation of the bladder) with hematuria (blood in the urine) and kidney failure (kidneys stop working). Record review of Resident #8's Comprehensive MDS Assessment, dated 06/21/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 10. The Comprehensive MDS Assessment indicated that the resident was frequently incontinent for bladder and bowel. Record review of Resident #8's Comprehensive Care Plan, dated 09/04/2025, reflected that the resident had incontinence and one of the interventions was to assist during toilet use or personal hygiene. An observation on 09/18/2025 at 12:58 PM revealed CNA F was about to do Resident #8's incontinent care. She washed her hands and put on a pair of gloves. She took a brief from a drawer and placed it on top of the resident's overbed table. She then took a towel from the drawer and wet it. She then pulled off the resident's pants and unfastened the brief. She cleaned the resident's perineal area (area between the legs) using the wet towel. She cleaned the top part of the resident's perineal area and then the sides of the perineal area. After cleaning the sides of the perineal area, she cleaned the middle portion of the perineal area with the same face towel that she used to clean the sides of the perineal area. She turned the resident and used the same towel to clean the resident's bottom. She cleaned the resident's bottom from back to front. After cleaning the resident's bottom, she took the brief from the resident's overbed table and placed it under the resident and fixed it. 2. Record review of Resident #15's Face Sheet, dated 09/18/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with a personal history of urinary tract infection. Record review of Resident #15's Comprehensive MDS Assessment, dated 08/21/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 10. The Comprehensive MDS Assessment indicated that the resident was frequently incontinent for bladder and bowel. Record review of Resident #15's Comprehensive Care Plan, dated 09/12/2025, reflected that the resident had incontinence and one of the interventions was to assist during toilet use or personal hygiene. Observation on 09/19/2025 at 12:47 PM revealed CNA F was about to do Resident #15's incontinent care. She washed her hands and put on a pair of gloves. She took a brief and a towel from a drawer. She wet the towel. She took off the resident's pants, unfastened the brief, and pushed it in the middle of the legs. She then cleaned the resident's perineal area using the wet towel. She cleaned the top part of the resident's perineal area and then the sides (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the perineal area. After cleaning the sides of the perineal area, she cleaned the middle portion of the perineal area with the same face towel that she used to clean the sides of the perineal area. She turned the resident and used the same towel to clean the resident's bottom. After cleaning the resident's bottom, she took the brief from the top of the drawer and placed it under the resident. She rolled back the resident and fixed the brief. In an interview on 09/18/2025 at 1:08 PM, CNA F stated the proper technique during incontinent care would be to use a wipe and then discard. She said if she was using wipes, it should be one stroke then discard. She said she should have used another face towel to clean the middle portion of the resident's perineal area. She said she was not aware she cleaned Resident #15's bottom from back to front. She said her actions could cause urinary tract infections. She said she should slow down and think while she was doing incontinent care to protect the residents from infections. 3. Record review of Resident #21's Face Sheet, dated 09/18/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with chronic kidney disease. Record review of Resident #21's Quarterly MDS Assessment, dated 09/09/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated the resident was incontinent for bladder and bowel. Record review of Resident #21's Comprehensive Care Plan, dated 07/17/2025, reflected the resident had ADL self-care performance and one of the interventions was to provide assist during toilet use and personal hygiene. Observation on 09/19/2025 at 10:39 AM revealed CNA E about to do Resident #21's incontinent care. He washed his hands and put a towel on the resident's overbed table. He took the box of gloves from the wall and wipes and put it on the overbed table. He cleaned the perineal (area between the thighs) area with a wipe. He cleaned the top portion of the perineal area then the sides of the perineal area. after cleaning the sides, he used the same wipe to clean the middle portion of the perineal area. He rolled the resident and cleaned the bottom. After cleaning the bottom, he rolled the soiled brief towards the middle and cleaned the resident's bottom. After cleaning the bottom, he rolled back the resident and cleaned again the resident's perineal area twice with a wet towel. He cleaned the sides again and then the middle portion of the perineal area. After cleaning the perineal area, he fixed the brief. In an interview on 09/18/2025 at 11:04 AM, CNA E stated the wipes that he used to clean the side of the front part should have been discarded and he should have used a new wipe when he cleaned the middle part He said the wipe used on the sides where already dirty and Resident #21 might get a urinary tract infection. In an interview on 09/19/2025 at 7:01 AM, the DON stated the staff cannot use wipes or face towels that were used to clean the sides of the perineal area to clean the middle portion of the perineal area. He said the unwanted microorganisms (organisms that is too small to be seen) from the sides could be introduced and could eventually cause UTI especially for women. He said even though the staff cleaned the middle portion using a front to back technique, if they used soiled wipes and soiled face towels, it was still wrong. He said what should have done was one stroke, discard. He said, in cleaning the bottom, it should be from front to back and not the other way around because the microorganisms from the anal area will go to perineal area. He said, the staff should use wipes and not face towels because first, they have supplies of wipes, and second the face towel could be abrasive. He said he was made aware by CNA E and CNA F about the issue, and they already had a one-on-one in-service. He said they were checked off for incontinent care, so he did not know what happened. He said the expectation was for the staff to do the proper technique when providing incontinent care. In an interview on 09/19/2025 at 7:33 AM, ADON A stated she was surprised when she heard about the issue during incontinent care because they just went over with the staff about pericare a few weeks ago. She said the aides did the procedure properly. She said the technique should have been, one wipe, discard. She said it was not acceptable to use the wipes used cleaning the sides of the perineal area and re-use to clean the middle part because the middle part was the one prone to female residents having UTI. She said cleaning the bottom was from front to back so as not to introduce microorganism to the perineal area. She said cleaning the bottom back to the front could also cause UTI. She said an in-service about incontinent care was already initiated and (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	her expectation was for the staff to follow the proper technique when providing incontinent care. She said they would closely monitor the staff adherence to the procedure of incontinent care. In an interview on 09/19/2025 at 8:02 AM, the Administrator stated she was made aware about the issue during incontinent care. She said CNA E told her what happened. She said the aides had previous training so she did not know what happened. She said the expectation was for the staff to use one wipe at a time and to wipe the bottom from front to back. She said the DON already started an in-service about incontinent care. She said it seemed like a lot more training about pericare should be done. Record review of the facility's policy entitled Urinary Continence and Incontinence - Assessment and Management Strategy, Delivery, Performance revised 09/2024 reflected Policy Statement: 1. The staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence . Policy Interpretation and Implementation . 2. Relevant information . f. additional information such as the type and frequency of physical assistance necessary for the resident. Policy and procedure for Incontinent Care was requested via email to the Administrator on 09/18/2025 at 12:09 PM and 09/19/2025 at 10:21 AM but was not provided prior to exit. Record review of the facility's Competency Assessment Peri Care 2018 MED-PASS, Inc. revised February 2018 reflected A) Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition . For a female resident . b. Wash perineal area, wiping from front to back . (2) Continue to wash the perineum moving from inside outward to the thighs. Rinse perineum thoroughly in same direction, using fresh water and a clean washcloth . e. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation ,interview and record reviews the facility failed to ensure informed consent prior to installation. The facility failed to ensure Resident #5, #9, #10, #11, #30, and #46 had physician orders for the pivot assist bars attached to the residents' bed. This failure could place residents at risk of having unnecessary equipment installed on their beds .Findings included: 1. Record review of Resident #5's Face Sheet, dated 09/18/25, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness and Alzheimer's disease (cognitive decline). Record review of Resident #5's Comprehensive MDS Assessment, dated 08/15/25, reflected the resident had severe cognitive impairment with a BIMS score of 3. The Comprehensive MDS Assessment indicated that the resident had an active diagnosis of muscle weakness. Record review of Resident #5's Comprehensive Care Plan, dated 09/09/25, reflected the resident had a history of falls, with his last fall occurring on 08/31/25. The care plan did not include the pivot assist bars as an intervention. Record review of Resident #5's physician orders, dated 09/18/25, reflected no physician orders for the pivot assist bars. Observation on 09/17/2025 at 10:28 AM revealed Resident #5 had pivot assist bars on both sides of the bed. 2. Record review of Resident #9's Face Sheet, dated 09/18/25, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness and history of falls. Record review of Resident #9's Comprehensive MDS Assessment, dated 07/02/25, reflected the resident had an intact cognitive response with a BIMS score of 14. The Comprehensive MDS Assessment indicated that the resident had an active diagnosis of repeated falls and muscle weakness. Record review of Resident #9's Comprehensive Care Plan, dated 07/18/25, reflected the resident had a history of falls, with his last fall occurring on 08/03/25. The care plan did not include the pivot assist bars as an intervention. Record review of Resident #9's physician orders, dated 09/18/25, reflected no physician orders for the pivot assist bars. Observation on 09/17/2025 at 11:25 AM revealed Resident #9 had pivot assist bars on both sides of the resident's bed 3. Record review of Resident #10's Face Sheet, dated 09/18/25, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with senile degeneration of brains. Record review of Resident #10's Comprehensive MDS Assessment, dated 07/27/25, reflected the resident had a moderate cognitive impairment with a BIMS score of 8. The Comprehensive MDS Assessment indicated that the resident had an active diagnosis of coronary artery disease (disease of the heart). Record review of Resident #10's Comprehensive Care Plan, dated 08/13/25, reflected the resident had a history of falls, but the care plan did not include the pivot assist bars as an intervention. Record review of Resident #10's physician orders, dated 09/18/25, reflected no physician orders for the pivot assist bars. Observation on 09/17/2025 at 10:35 AM revealed Resident #10 had pivot assist bars on both sides of the resident's bed. 4. Record review of Resident #11's Face Sheet, dated 09/18/25, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with a history of fall, and muscle weakness. Record review of Resident #11's Comprehensive MDS Assessment, dated 07/12/25, reflected the resident was moderately cognitively impaired with a BIMS score of 8. The Comprehensive MDS Assessment indicated that the resident had an active diagnosis of repeated falls and muscle weakness. Record review of Resident #11's Comprehensive Care Plan, dated 07/13/25, reflected the resident had a history of falls, but the care plan did not include the pivot assist bars as an intervention. Record review of Resident #11's physician orders, dated 09/18/25, reflected no physician orders for the pivot assist bars. Observation on 09/17/2025 at 11:06 AM revealed Resident #11 had pivot assist bars on both sides of the resident's bed. 5. Record review of Resident #30's Face Sheet, dated 09/18/25, (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with a muscle weakness and the need of assistance for personal care. Record review of Resident #30's Comprehensive MDS Assessment, dated 07/02/25, reflected the resident had a moderate cognitive impairment with a BIMS score of 9. The Comprehensive MDS Assessment indicated that the resident had an active diagnosis of and muscle weakness. Record review of Resident #30's Comprehensive Care Plan, dated 07/13/25, reflected the resident had a history of falls, but the care plan did not include the pivot assist bars as an intervention. Record review of Resident #30's physician orders, dated 09/18/25, reflected no physician orders for the pivot assist bars. Observation on 09/17/2025 at 11:11 AM revealed Resident #30 had pivot assist bars on both sides of the resident's bed. 6. Record review of Resident #46's Face Sheet, dated 09/17/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #46 had diagnoses of muscles weakness. Record review of Resident #46's Quarterly MDS Assessment, dated 09/09/25, reflected Resident #46 had a moderate cognitive impairment with a BIMS score of 12. The Quarterly MDS Assessment reflected an active diagnosis of muscle weakness and osteoarthritis of both knees. Record review of Resident #46's Comprehensive Care Plan, dated 09/06/25, reflected the resident had a history of falls, but the care plan did not include the pivot assist bars as an intervention. Record review of Resident #46's physician orders, dated 09/18/25, reflected no physician orders for the pivot assist bars. Observation on 09/17/2025 at 10:51 AM revealed Resident #46 had pivot assist bars on both sides of the resident's bed. In an interview on 09/18/25 at 1:48 PM, LVN D, was told by the Surveyor of Resident #30 had pivot assist bars on both sides of his bed, but no physician orders were observed for the devices. She stated the resident did not have physician orders for the equipment. She stated the resident should have physician orders for the bars because it could be a form of restraint and safety hazards. In an interview on 09/18/25 at 2:15 PM, ADON A was told by the Surveyor of Resident #5, #9, #10, #11, #30, and #46 not having physician orders for the pivot assist bars on the beds. She stated the bed came with the bars on them. She stated the resident did use the bars to reposition themselves. She stated she did not think physician orders were needed for the bars. She stated she would follow up with the DON to see about getting physician orders for the equipment. In an interview on 09/19/25 at 11:08 AM, the DON was told by the Surveyor of Resident #5, #9, #10, #11, #30, and #46, not having physician orders for the pivot assist bars. He stated this was brought to his attention by ADON after the Surveyor brought it to ADON A's attention, and they were now completing bedrail assessments for the residents, care planning the use of the bedrails, and obtaining physician orders for the devices. He stated he was not sure of the risk for the resident because the bars had been on the beds for over six years, but they would ensure physician orders for the pivot assist bars were obtained going forward. The facility's policy RESTRAINTS dated 06/17 reflected, It is the policy of the facility to refuse to restrain residents for any cause. Should a resident have cause for need of a restraint, the physician will be notified immediately, and Texas state regulations will be followed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals that met the needs of each resident for four (Resident #4, Resident #7, Resident #21, and Resident #61) of twenty residents reviewed for pharmaceutical services. 1. The facility failed to ensure Resident #4 was not self-administering her pain ointment without an assessment on 09/17/2025. 2. The facility failed to ensure Resident #7 was not self-administering some medications without an assessment on 09/17/2025. 3. The facility failed to ensure Resident #21 was not self-administering her morning medications without an assessment on 09/17/2025. 4. The facility failed to ensure Resident #61 was not self-administering her eye drops without an assessment on 09/17/2025. These failures could place residents at risk of not receiving medications as ordered, potential overdose, and adverse effects. Findings include: 1. Record review of Resident #4's Face Sheet, dated 09/18/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with osteoarthritis (inflammation of the joints). Record review of Resident #4's Comprehensive MDS Assessment, dated 07/21/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had osteoarthritis. Record review of Resident #4's Comprehensive Care Plan, dated 08/04/2025, reflected that the resident had chronic pain R/T arthritis to foot and one of the interventions was to monitor pain quality, severity, location, and aggravating factors. The Comprehensive Care Plan did not indicate that the resident could self-administer her medications. Record review of Resident #4's Physician's Order, dated 09/27/2023, reflected Voltaren Arthritis Pain External Gel 1 % Diclofenac Sodium (Topical)). Apply to . topically every 4 hours as needed for pain. Record review of Resident #4's Clinical Assessment Notes on 09/17/2025 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 09/17/2025 at 9:08 AM revealed Resident #4 was in her bed, awake. A tube of diclofenac sodium topical gel was observed on top of the resident's overbed table. The resident said she was the one applying the ointment and that the staff knew she was the one doing it every time she needed it. An observation on 09/18/2025 at 10:43 AM revealed the tube of diclofenac sodium topical gel was still on top of Resident 4's overbed table. During an observation and interview on 09/18/2025 at 11:28 AM, RN B stated the pain ointment should not be inside Resident #4's room. She said it should be inside the nurses' cart because the nurses were supposed to be the one administering the pain ointment. She said she did not know who left the pain ointment with the resident and she did not notice there was a tube of pain ointment on the resident's overbed table. She said the resident might use it more than the recommended could cause skin redness or dryness. 2. Record review of Resident #7's Face Sheet, dated 09/18/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with gastro-esophageal reflux disease (stomach acid repeatedly flows back into the tube connecting your mouth and stomach). Record review of Resident #7's Comprehensive MDS Assessment, dated 07/16/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment indicated the resident had gastro-esophageal reflux disease. Record review of Resident #7's Comprehensive Care Plan, dated 07/23/2025, reflected that the resident was at risk for pain or discomfort and one of the interventions was to observe any s/s of non-verbal pain like tearing eyes. Record review of Resident #7's Physician's Order, dated 04/25/2025, reflected Aluminum-Magnesium-Simethicone Suspension 200-200-20 MG/5ML (Alum &Mag Hydroxide-Simeth) Give 30 ml by mouth every 4 hours as needed for indigestion (pain or discomfort after eating). Record review of Resident #7's Physician Order, dated 10/20/2021, reflected (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Refresh Solution 1.4-0.6 % (Polyvinyl Alcohol Povidone PF) Instill 1 drop in both eyes two times a day for Dry eyes. Record review of Resident #7's Physician Order on 09/17/2025 reflected no order for TUMS. Record review of Resident #7's Physician Order on 09/17/2025 reflected no order for oral analgesia. Record review of Resident #7's Clinical Assessment on 09/17/2025 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 09/17/2025 at 9:46 AM revealed Resident #7 was sitting at the side of her bed. A bottle of TUMS (medication for heartburn [burning pain in the chest] and indigestion), 2 eyedrops, and a tube of oral analgesic were noted on the resident's side table. She said those were her medications and she would sometimes take them if she needed them. During an observation and interview on 09/18/2025 at 7:13 AM, RN C stated there should be no medications inside the residents' rooms because the medication aide was the one administering most of the medications, the nurses were the ones giving the PRNs and doing the treatments as well. She said the residents had no reason to have medications inside the room. She went inside the resident's room and saw the bottle of TUMS, two eyedrops, and a tube of oral analgesia. She talked to the resident and took the medications mentioned. She said the resident was oriented and cognitive but unless they have an assessment that they could self-medicate, there should be no medications inside the residents' rooms. She said the resident did not have an assessment that she could administer her medications unsupervised. 3. Record review of Resident #21's Face Sheet, dated 09/18/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with anemia (low red blood cells in the blood). Record review of Resident #21's Quarterly MDS Assessment, dated 09/09/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated that the resident had anemia. Record review of Resident #21's Comprehensive Care Plan, dated 07/17/2025, reflected the resident had anemia and encourage intake of foods high in iron and vitamin C. Record review of Resident #21's Physician Order, dated 09/16/2025, reflected Ascorbic Acid Tablet 500 MG Give 1 tablet by mouth two times a day for supplement for 15 Days. Record review of Resident #21's Physician Order, dated 05/18/2025, reflected Metformin HCl Oral Tablet 500 MG (Metformin HCl). Give 1 tablet by mouth two times a day for DM. Record review of Resident #21's Clinical Assessment on 09/17/2025 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 09/17/2025 at 9:56 AM revealed Resident #21 was in her bed, awake. It was observed that the resident was about to take three pills from a small cup that was on her tray. She said the cup was left by the staff and the staff told her to take the medications after she was done with breakfast. She said the medications might be vitamin C, metformin, and she did not know what the third pill was. She said she already took the other pills. She said it was not the first time that her medications were left with her. She said she did not know the name of the staff that left the medications. In an interview on 09/18/2025 at 6:51 AM, MA G stated medications should not be left with the residents because the residents might not take them or just throw the medications away. She said even though a resident did not have any issue with swallowing, she should wait for the resident to consume all the medications before leaving the room. She said she left the medications because there was a resident that was about to fall. She said she told the resident that she would come back. She said she should have brought the medication with her before leaving the room, put it back in the cart, or called somebody else to help the resident that she said was about to fall. In an interview on 09/18/2025 at 10:39 AM, Resident #21 reiterated that the medication aide left her medications with her the day before and told her to take them after breakfast. She said the staff did not tell her that somebody was falling or that she needed to go assist another resident. She said the staff did not come back to check if she had already taken the medications. 4. Record review of Resident #61's Face Sheet, dated 09/18/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with need for assistance with personal care and delirium (disturbed mental (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455627	A. Building B. Wing	09/19/2025

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

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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 - Some	state characterized with confusion and rapid changes in behavior). Record review of Resident #61s Comprehensive MDS Assessment, dated 08/28/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had delirium. Record review of Resident #61's Comprehensive Care Plan, dated 09/12/2025, did not reflect that the resident could self-administer her medications. Record review of Resident #61's Physician's Order on 09/17/2025 reflected no order for eye drops. Record review of Resident #61's Clinical Assessment Notes on 09/17/2025 reflected no assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications. Observation and interview on 09/17/2025 at 9:28 AM revealed Resident #61 was in her bed, awake. It was observed that an eye drop was on top of the resident's side table. The resident said she was using the eye drop every morning because her eyes were dry in the morning most of the time. She said she was not sure if the staff knew she was using an eye drop. In an interview on 09/19/2025 at 6:47 AM, LVN H stated she was not aware that Resident #61 had an eye drop inside her room. She said there should be no medications inside the residents' room unless they were assessed that the residents were capable of taking medications unsupervised. She said she would talk to the resident to let her know that she would get her eye drop. She would also see if the resident needed eye drops so she could request an order for the eye drops. In an interview on 09/19/2025 at 7:01 AM, the DON stated the staff should never leave any medication inside the resident's room for them to take unsupervised. He said the resident might not take them, hide them, or take them with them along with the next dose. He said the resident could overdose or their underlying conditions were not getting well because they were not able to take their medications. He said the resident might choke and nobody would be there with her. He said the staff should make sure that the medications were consumed before leaving the room. He said, as per MA G, she left the pills because somebody was about to fall that was why she left the pills to the resident who was oriented but if the medication aide was on other halls when the pills were observed inside the room, then that was another story. He said pain ointments, eye drops, and TUMS were supposed to be administered by the staff. He said the residents should not be administering them unless they were assessed fit to administer them by themselves. He said the expectation was that the staff would not let the residents take the medication by themselves and for staff to scan the room if there were medication inside the room because one concern was the staff already gave them the medications and the resident would still get from her supply. He said he would also check if the staff requested physician orders for the medications that were inside the room if needed by the resident. He said he already initiated an in-service pertaining to not leaving any medication with the resident to take unsupervised and to scan the room for any medications. In an interview on 09/19/2025 at 7:33 AM, ADON A stated leaving pills inside the room was a no-no because a lot of things could happen. She said the resident might choke and nobody would be there to help her. She said the staff should wait for the resident to be done taking the medication before leaving the room. She said even oriented residents could have problems when swallowing the medications. She said oriented residents could have a clear mind to hide the pills if they do not want to take them. She said confused residents might enter other residents' rooms and take the medication. She said the same principle applied to the eyedrops, TUMS, and oral analgesia. She said the medications mentioned should be administered by the staff unless the residents were assessed competent with self-administration. She said the DON already initiated an in-service about medication administration. She said they would monitor closely because they could not wait for somebody to choke before the lesson was learned. In an interview on 09/19/2025 at 8:02 AM, the Administrator stated no medications should be left inside the room because the resident might overmedicate. She said the resident might take the medication inside their room every hour and nobody would know. She said the expectation was for the staff not to leave any medication inside the room for the resident to administer by himself. She said the DON already started an in-service about not leaving the medications with the resident. Record review of the facility's policy entitled, Administering (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455627	A. Building B. Wing	09/19/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medications Strategy, Delivery, Performance revised 08/2024 reflected Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation . 1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so . 27. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.

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	455627	A. Building B. Wing	09/19/2025

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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 eight (Residents #4, #7, #8, #21, #23, #31, #51, and #61) of eighteen residents reviewed for medication storage. 1. The facility failed to ensure that Resident #4's pain ointment was not inside the room on 09/17/2025. 2. The facility failed to ensure that Resident #7's TUMS, eye drops, and oral analgesia were not inside the room on 09/17/2025. 3. The facility failed to ensure that a wound cleanser was not left inside Resident #8's room on 09/17/2025. 4. The facility failed to ensure Resident #21's medication was not left inside the room on 09/17/2025 and 09/18/2025. 5. The facility failed to ensure that a tube of zinc oxide (medicated cream used to prevent skin irritation) was not left inside Resident #23's room on 09/17/2025. 6. The facility failed to ensure a bottle of hydrogen peroxide was not left inside Resident #31's room [ROOM NUMBER]/17/2025. 7. The facility failed to ensure a tube of zinc oxide was not left inside Resident #51's room on 09/17/2025. 8. The facility failed to ensure Resident #61's eye drop was inside the room on 09/17/2025. These failures could place residents at risk of misuse of medications that could lead to overdosing or underdosing. Findings include: 1. Record review of Resident #4's Face Sheet, dated 09/18/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with osteoarthritis. Record review of Resident #4's Comprehensive MDS Assessment, dated 07/21/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had osteoarthritis. Record review of Resident #4's Comprehensive Care Plan, dated 08/04/2025, reflected that the resident had chronic pain R/T arthritis to foot and one of the interventions was to monitor pain quality, severity, location, and aggravating factors. Record review of Resident #4's Physician's Order, dated 09/27/2023, reflected Voltaren Arthritis Pain External Gel 1 % Diclofenac Sodium (Topical)). Apply to . topically every 4 hours as needed for pain. During an observation and interview on 09/17/2025 at 9:08 AM revealed Resident #4 was in her bed, awake. A tube of diclofenac sodium topical gel was observed on top of the resident's overbed table. The resident said the ointment had been in her room and had always been on top of the overbed table or her side table where she easily accessed it. An observation on 09/18/2025 at 10:43 AM revealed the tube of diclofenac sodium topical gel was still on top of Resident 4's overbed table. During an observation and interview on 09/18/2025 at 11:28 AM, RN B stated the pain ointment should not be inside Resident #4's room. She said it should be inside the nurses' carts because the nurses were supposed to be the ones administering the pain ointment. She said she did not know who left the pain ointment with the resident and she did not notice there was a tube of pain ointment on the resident's overbed table. She said the resident might use it more than the recommended and could result in skin redness or dryness. RN B went inside the resident's room and took the tube of pain ointment. 2. Record review of Resident #7's Face Sheet, dated 09/18/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with gastro-esophageal reflux disease and dementia. Record review of Resident #7's Comprehensive MDS Assessment, dated 07/16/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment indicated the resident had gastro-esophageal reflux disease and dementia (a condition characterized by loss of memory and ability to reason). Record review of Resident #7's Comprehensive Care Plan, dated 07/23/2025, reflected that the resident had gastro-esophageal reflux disease and dementia. Record review of Resident #7's Physician's Order, dated 04/25/2025, reflected Aluminum-Magnesium-Simethicone Suspension 200-200-20 MG/5ML (Alum &Mag Hydroxide-Simeth) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455627	A. Building B. Wing	09/19/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give 30 ml by mouth every 4 hours as needed for indigestion. Record review of Resident #7's Physician Order, dated 10/20/2021, reflected Refresh Solution 1.4 - 0.6 % (Polyvinyl Alcohol Povidone PF) Instill 1 drop in both eyes two times a day for Dry eyes. Record review of Resident #7's Physician Order on 09/17/2025 reflected no order for TUMS. Record review of Resident #7's Physician Order on 09/17/2025 reflected no order for oral analgesia. During an observation and interview on 09/17/2025 at 9:46 AM revealed Resident #7 was sitting at the side of her bed. A bottle of TUMS, 2 eyedrops, and a tube of oral analgesic were noted on the resident's side table. She said those were her medications and she always put them on top of her side table. 3. Record review of Resident #8's Face Sheet, dated 09/18/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with a personal history of diseases of the skin and subcutaneous (under the skin) tissue. Record review of Resident #8's Comprehensive MDS Assessment, dated 09/08/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 10. The Comprehensive MDS Assessment indicated the resident had skin issues. Record review of Resident #8's Comprehensive Care Plan, dated 09/04/2025, reflected that the resident had a skin tear on the left elbow and right forearm and one of the interventions was to provide wound care as ordered. Record review of Resident #8's Physician Order, dated 08/29/2025, reflected wound care: cleanse wound (left elbow) with NS, pat dry, apply moisturizer and cover arm with tubi grip (elastic tubular bandage) one time a day. Record review of Resident #8's Physician Order, dated 08/29/2025, reflected Wound care: cleanse wound to right forearm with NS, pat dry, apply moisturizer and cover with tubi grip one time a day. During an observation and interview on 09/17/2025 at 9:40 AM revealed Resident #8 was in her wheelchair, awake. It was observed that there was a wound cleanser on the resident's sink. She said the staff used it when she had a skin tear to both arms. She said the skin tears were already healed. 4. Record review of Resident #31's Face Sheet, dated 09/18/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with repeated falls. Record review of Resident #31's Quarterly MDS Assessment, dated 08/30/2025, reflected the resident had a moderate impairment in cognition with a BIMS score of 08. The Quarterly MDS Assessment indicated that the resident was at risk of repeated falls. Record review of Resident #31's Comprehensive Care Plan, dated 07/25/2025, reflected the resident had an actual fall due to poor balance and one of the interventions was to monitor bruises. Record review of Resident #31's Physician Order on 09/17/2025 reflected that the resident did not have any wound care. During an observation and interview on 09/17/2025 at 9:38 AM revealed Resident #31 was in her wheelchair, awake. A bottle of hydrogen peroxide was observed on top of the resident's sink. The resident said the hydrogen peroxide was for her feet. 5. Record review of Resident #51's Face Sheet, dated 09/18/2025, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with benign prostatic hyperplasia with lower urinary tract symptoms. Record review of Resident #51's Quarterly MDS Assessment, dated 09/07/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated that the resident was incontinent for bowel. Record review of Resident #51's Comprehensive Care Plan, dated 09/05/2025, reflected the resident had an ADL self-care performance and one of the interventions was to inspect the skin. Record review of Resident #51's Physician Order, dated 09/03/2025, reflected BARRIER CREAM/OINT AFTER EACH INCONTINENT EPISODE AND PRN AS INDICATED every shift. An observation on 09/17/2025 at 9:43 AM revealed Resident #51 was not inside the room. A tube of zinc oxide of hydrogen peroxide was observed on top of the resident's sink. During an observation and interview on 09/18/2025 at 7:13 AM, RN C stated all medications should be inside the nurses' carts or the medication aide' cart. She said the zinc oxide, hydrogen peroxide, and the wound cleanser should also be stored inside the carts. She said medications should not be stored inside the resident's rooms because the residents might consume the medications more than the recommended and could result to overdose. She said zinc oxide, hydrogen peroxide, and wound cleanser should not be inside the room as well because the residents might accidentally consume them, especially confused residents, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455627	A. Building B. Wing	09/19/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and could result to adverse reactions like stomach upset. She went inside the residents' rooms and took the eyedrops, TUMS, oral analgesia, hydrogen peroxide, and wound cleanser. She said she would also check the rooms on her hall to see if there were medications or items used to facilitate healing. In an interview on 09/18/2025 at 1:08 PM, CNA F stated RN C told her about the zinc oxide and calmoseptine that were found inside the room. She said the zinc oxide should be in the cart and just ask for it when needed. She said the zinc oxide could be placed in a small cup so that the tube would stay in the cart. She said the facility also had them in sachet so just bring one or two, depending on the need. She said they should not be left inside the room where the resident or other residents could reach it and accidentally put it in their mouth. She said she was not sure what could happen but she was sure zinc oxide and calmoseptine were not for consumption. She said the resident could put it in their eyes that could cause reactions. 6. Record review of Resident #21's Face Sheet, dated 09/18/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with anemia and kidney disease. Record review of Resident #21's Quarterly MDS Assessment, dated 09/09/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated that the resident had anemia and kidney disease. Record review of Resident #21's Comprehensive Care Plan, dated 07/17/2025, reflected the resident had anemia and encourage intake of foods high in iron and vitamin C. Record review of Resident #21's Physician Order, dated 09/16/2025, reflected Ascorbic Acid Tablet 500 MG Give 1 tablet by mouth two times a day for supplement for 15 Days. Record review of Resident #21's Physician Order, dated 05/18/2025, reflected Metformin HCl Oral Tablet 500 MG (Metformin HCl). Give 1 tablet by mouth two times a day for DM. During an observation and interview on 09/17/2025 at 9:56 AM revealed Resident #21 was in her bed, awake. It was observed that the resident was about to take three pills from a small cup that was on her tray. She said the cup was left by the staff and the staff told her to take the medications after she was done with breakfast. In an interview on 09/18/2025 at 6:51 AM, MA G stated medications should not be left with the residents because the residents might not take them or just throw the medications away. She said she left Resident #21's medications because there was a resident that was about to fall. She said she should have brought the medication with her before leaving the room, put it back in the cart, or called somebody else to help the resident that she said was about to fall. An observation on 09/18/2025 at 10:29 AM revealed CNA E provided incontinent care to Resident #21. He brought with him three sachets of calmoseptine. Before fastening the brief, he opened a calmoseptine ointment and spread it on the resident's bottom. He then fastened the brief and washed his hands. He still had two sachets of calmoseptine on hand and he left them on top of the resident's dresser beside the bed and left the room. 7. Record review of Resident #23's Face Sheet, dated 09/18/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with weakness. Record review of Resident #23's Quarterly MDS Assessment, dated 07/15/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated that the resident was at risk for pressure ulcers. Record review of Resident #23's Comprehensive Care Plan, dated 08/07/2025, reflected the resident had impairment to skin integrity and one of the interventions was to use lotion on dry skin. Record review of Resident #23's Physician Order, dated 02/14/2025, reflected Moisture barrier ointment as indicated to keep irritants or moisture from skin surface every shift. During an observation and interview on 09/17/2025 at 10:43 AM revealed Resident #23 was in her bed, awake. A tube of zinc oxide was observed on top of the resident's overbed table. The resident just shrugged her shoulders when asked who left the zinc oxide on top of the overbed table. During an observation and interview on 09/18/2025 at 10:40 AM, LVN D said it should not be left inside the room she went inside and took the sachets. She called CNA E and told him not to leave the sachets inside the rooms of the residents because the resident might use them inappropriately or confused residents might consume them. She said pills should not be left with a resident. She said if the staff needed to leave, put the medication back to the cart. She also said the zinc oxide should be inside the cart and the staff should just ask if needed. 8. Record (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455627	A. Building B. Wing	09/19/2025

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of Resident #61's Face Sheet, dated 09/18/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with need for assistance with personal care and delirium Record review of Resident #61s Comprehensive MDS Assessment, dated 08/28/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had delirium. Record review of Resident #61's Physician's Order on 09/17/2025 reflected no order for eye drops. Observation and interview on 09/17/2025 at 9:28 AM revealed Resident #61 was in her bed, awake. It was observed that an eye drop was on top of the resident's side table. The resident said she was using the eye drop every morning because her eyes were dry in the morning most of the time. She said she was not sure if the staff knew she was using an eye drop. In an interview on 09/19/2025 at 6:47 AM, LVN H stated she was not aware that Resident #61 had an eye drop inside her room. She said the eye drop should be inside the cart because the staff were supposed to administer them. She said there should be no medications inside the residents' room because the resident might overuse it. In an interview on 09/19/2025 at 7:01 AM, the DON stated medications should not be stored inside the resident's room. He said TUMS, eyedrops, zinc oxide, hydrogen peroxide, pain ointments, and wound cleanser should be inside the carts to secure them. He said the resident could overdose and some form of medications that were applied topically could be harmful when ingested. He said when using calmoseptine, the staff should only get what was supposed to be used from the supply room. He said he already initiated an in-service about medication storage. In an interview on 09/19/2025 at 7:33 AM, ADON A stated medications should not be inside the residents' rooms and should be in the carts. The pills, eye drops, pain ointments, zinc oxides, hydrogen peroxide, and wound cleanser should be secured so the residents, especially the confused resident, would not get a hold of them. She said the residents could overdose because nobody was monitoring how often the resident was taking the medication. She said residents with poor eyesight could mistakenly thought that zinc oxide and calmoseptine were sauce and put them on their food. She said the expectation was for the staff not to leave any medication inside the room. She said the zinc oxides, hydrogen peroxide, and wound cleanser were forms of medication because they were used for wound care. She said the DON already started an in-service about medication storage. In an interview on 09/19/2025 at 8:02 AM, the Administrator stated the expectation was for the staff to be mindful not to leave any medication inside the room and to scan the room to make sure there were no medications inside the resident's rooms. She said the residents might consume the medications inappropriately. She said the DON already started an in-service about medication storage. Record review of the facility's policy entitled, Medication Labeling and Storage reflected Policy Statement: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys . 9. Antiseptics, disinfectants, and germicides used in any aspect of resident care . shall be stored separately from regular medications.

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	455627	A. Building B. Wing	09/19/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food and nutrition services. The facility failed to ensure frozen food items were properly labeled and dated when stored in the freezer. The facility failed to ensure open food products requiring refrigeration were stored appropriately after opening. Failure to store open, perishable food products requiring refrigeration appropriately after opening may lead to the growth of harmful bacteria, increasing the risk of foodborne illness among residents.Tag: F812/N4363S/S= E Surveyor Name(s): Joycelynn [NAME] Supervisor: [NAME] Findings include:[SP1] [JB2] Observations on 09/17/25 from 9:15 AM to 9:30 AM in the facility's only kitchen revealed: One large sealed bag of frozen French fries, located in the freezer, was not labeled with the date stored. One large sealed package of beef, which appeared to be brisket, located in the freezer, was not labeled with the date stored. One large open container of teriyaki sauce, labeled Refrigerate After Opening, was stored unrefrigerated in the dry storage area. One large open container of soy sauce, labeled Refrigerate After Opening, was stored unrefrigerated in the dry storage area. In an interview on 09/19/25 at 9:05 AM, the DON acknowledged the importance of proper food storage to prevent foodborne illnesses. The DON stated that while he does not directly handle or label food in the kitchen, he is aware of the facility's food storage policies and the potential risks to residents if food is not stored appropriately. In an interview on 09/19/25 at 9:15 AM, the Chief Kitchen Manager, who reported being employed at the facility for seven years, stated that the current process for managing perishable condiments, such as soy sauce and teriyaki sauce, includes thoroughly wrapping, labeling, dating, and storing them in the appropriate area. He acknowledged that both containers should have been refrigerated after opening and stated they would be discarded now that he was made aware of the oversight. He stated the items may have been mistakenly placed in dry storage by another staff member after use. He confirmed there were standard operating procedures in place for handling opened condiments and sauces, and that food items were expected to be labeled, dated, and stored according to policy. He denied any recent issues or concerns from staff regarding the storage of perishable items. In an interview on 09/19/25 at 9:22 AM, the Food and Beverage Manager stated that, per facility policy, sauces such as soy sauce and teriyaki sauce must be labeled, dated, and refrigerated once opened, and that any product found improperly stored is disposed of. He reported that all staff were responsible for monitoring storage practices, with two team members, assigned to conduct regular sweeps to ensure compliance. He confirmed that staff receive training on proper food storage and safety procedures. He acknowledged that improper storage of food items could pose a risk to residents, including potential illness. In an interview on 09/19/25 at 9:33 AM, the Dietitian, who reported working at the facility since October 2021, stated that soy sauce can be stored at room temperature for up to 1-6 months to extend shelf life and was typically used within a month. Despite label instructions indicating refrigeration after opening, he expressed his belief that storing these items unrefrigerated was acceptable and noted he could reference external sources to support this practice. He acknowledged that perishable items removed from their original packaging should be labeled with an opened by and use by date and confirmed that proper food storage was essential to prevent health risks to residents. In an interview on 09/19/25 at 11:00 AM, the Administrator discussed food safety policies related to condiment storage. She stated that the facility has policies requiring proper storage of opened condiments, including refrigeration when indicated by labels. However, she also noted that the Dietitian has expressed that refrigeration may not always be necessary. The Administrator indicated that she would ultimately follow whatever the state regulatory authority decides regarding these guidelines. While she personally does not always (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455627	A. Building B. Wing	09/19/2025

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	refrigerate these items at home, she understands the importance of following labeling instructions in the facility to protect the health of the vulnerable resident population. She acknowledged that improper storage could pose risks to residents but appeared to defer final judgment to regulatory standards. In an interview on 09/19/25 at 11:20 AM, the Dietary Aide stated that everyone working in the kitchen was responsible for ensuring compliance with proper food storage practices. She emphasized that if any staff member observes food that was not properly labeled or stored, it was their duty to address the issue and notify one of the managers. She expressed awareness of the critical importance of maintaining proper food storage, especially because the facility serves a vulnerable population. She noted that improper food handling could lead to illness, which is particularly concerning given that many residents are already medically fragile. Record review of the facility's Food and Nutrition Services policy titled Food Storage (05/19/2025) revealed that all food must be stored properly to ensure safety and quality. The policy requires foods from approved sources to be stored in sanitary conditions, with perishable items covered, labeled, and dated upon opening or removal from original packaging. Time/temperature control for safety (TCS) foods must be discarded within designated timeframes, and refrigerators and freezers are to be maintained at specific temperatures with routine monitoring and documentation. The policy emphasizes proper rotation of stock using First-In, First-Out (FIFO), secure storage six inches off the floor, and segregation of personal food from facility food items to prevent contamination. Failure to comply with these standards may increase the risk of food spoilage and foodborne illness. Record review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.

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	455627	A. Building B. Wing	09/19/2025

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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 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 fifteen residents (Resident #8, Resident #15, Resident #21, and Resident #37) reviewed for infection control. 1. The facility failed to ensure CNA F performed hand hygiene and changed her gloves during Resident #8's incontinent care on 09/18/2025. 2. The facility failed to ensure CNA F performed hand hygiene and changed her gloves during Resident #15's incontinent care on 09/18/2025. 3. The facility failed to ensure CNA E performed hand hygiene and changed his gloves during Resident #21's incontinent care on 09/18/2025. 4. The facility failed to ensure RN B wore a gown while giving Resident #37's formula via g-tube, who had an order for enhanced barrier protection, on 09/18/2025. These failures could place residents at risk of cross-contamination and development of infections. Findings include: 1. Record review of Resident #8's Face Sheet, dated 09/18/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with kidney failure. Record review of Resident #8's Comprehensive MDS Assessment, dated 09/04/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 10. The Comprehensive MDS Assessment indicated the resident had kidney failure and incontinent for blader and bowel. Record review of Resident #8's Comprehensive Care Plan, dated 09/04/2025, reflected that the resident had incontinence and one of the interventions was to assist during toilet use or personal hygiene. An observation on 09/18/2025 at 12:58 PM revealed CNA F was about to do Resident #8's incontinent care. She washed her hands and put on a pair of gloves. She took a brief from a drawer and placed it on top of the resident's overbed table. She then took a towel from the drawer and wet it. She placed the wet towel on top of the brief. She then pulled off the resident's pants and unfastened the brief. She cleaned the resident's perineal area (area between the legs) using the wet towel. She turned the resident and cleaned the resident's bottom. After cleaning the resident's bottom, she took the brief from the resident's overbed table and placed it under the resident and fixed it. She did not change her gloves and did not hand hygiene all throughout the process. 2. Record review of Resident #15's Face Sheet, dated 09/18/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with a personal history of urinary tract infection. Record review of Resident #15's Comprehensive MDS Assessment, dated 08/21/2025, reflected that the resident had moderate impairment in cognition with a BIMS score of 10. The Comprehensive MDS Assessment indicated that the resident was frequently incontinent for bladder and bowel. Record review of Resident #15's Comprehensive Care Plan, dated 09/12/2025, reflected that the resident had incontinence and one of the interventions was to assist during toilet use or personal hygiene. Observation on 09/19/2025 at 12:47 PM revealed CNA F was about to do Resident #15's incontinent care. She washed her hands and put on a pair of gloves. She took a brief and a towel from a drawer. She placed the brief on top of the drawer. She wet the towel and also placed it on top of the drawer. She took off the resident's pants, unfastened the brief, and pushed it in the middle of the legs. She then cleaned the resident's perineal area using the wet towel that she placed on top of the drawer. After cleaning the perineal area, she washed the face towel and cleaned the resident's bottom. After cleaning the resident's bottom, she took the brief from the top of the drawer and placed it under the resident. She rolled back the resident and fixed the brief. She did not change her gloves throughout the process of incontinent care. In an interview on 09/18/2025 at 1:08 PM, CNA F stated there were no wipes inside the room that was why she used the towel. She said for Resident #15, she said she was not aware that she put the face towel on top of the drawer. She said the top of the drawer might be dirty rendering her towel dirty when she used it. She said she did wash her hands before both incontinent care. She said she was supposed to change her gloves (continued on next page)

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	455627	A. Building B. Wing	09/19/2025

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Denton Village by Purehealth	2500 Hinkle Dr Denton, TX 76201

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	after cleaning the residents' bottom and before touching the new briefs to prevent using dirty gloves. She said using soiled gloves could cause transfer of germs to the new brief. She said the hands should also be sanitized if she changed her gloves. She said she would be mindful the next time she would do incontinent care. 3. Record review of Resident #21's Face Sheet, dated 09/18/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with chronic kidney disease. Record review of Resident #21's Quarterly MDS Assessment, dated 09/09/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated that the resident was incontinent for bladder and bowel. Record review of Resident #21's Comprehensive Care Plan, dated 07/17/2025, reflected the resident had ADL self-care performance and one of the interventions was to provide assist during toilet use and personal hygiene. Observation on 09/19/2025 at 10:39 AM revealed CNA E about to do Resident #21's incontinent care. He washed his hands and put a towel on the resident's overbed table. He took the box of gloves from the wall and wipes and put it on the overbed table. He took a brief from the closet, opened it, and placed it beside the resident. He unfastened the brief and pushed it between the legs. He cleaned the perineal area with a wipe and then rolled the resident to her side. After rolling the resident to her side, he rolled the brief towards the middle and cleaned the resident's bottom. He then wet a face towel, put some perineal cleanser on it, and cleaned the resident's bottom again. After cleaning the bottom, he took another face towel to dry the bottom. He did not change his glove before touching the face towel that he used to dry up the resident's bottom. After drying the bottom, he took off his gloves and then put on a pair of gloves. He did not sanitize his hands before putting on the new pair of gloves. He then put some calmoseptine on the resident's bottom. He then rolled the soiled linen towards to the middle and then took the brief from the resident's side and placed it under the resident. He did not change his gloves after touching the soiled linen and before touching the new brief. He rolled back the resident and cleaned the perineal area again twice using a wet face towel. After cleaning the perineal area twice with a wet face towel. For both times, he used a face towel that was soaking wet. He used the soaking face towel to clean the perineal area starting from the sides to the middle. He took off his gloves and put on a pair of gloves. He did not sanitize before putting on the new pair of gloves. He then pulled the soiled linen with the soiled brief and fixed the brief. He did not change his gloves after touching the soiled linen. In an interview on 09/18/2025 at 11:04 AM, CNA E stated he should have sanitized his hands when he changed his gloves after touching the soiled linen and before touching the new brief. He said he should have sanitized his hands when he changed his gloves to make sure his hands were clean before touching the new pair of gloves. He said he did use a wet towel and since it was wet, the germs could seep to the other part of the face towel even though he folded the towel and used the other side. He said he would be extra careful in doing incontinent care. 4. Record review of Resident #37's Face Sheet, dated 09/18/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing). Record review of Resident #37's Comprehensive MDS Assessment, dated 07/02/2024, reflected the resident had a moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment indicated that the resident had a feeding tube (medical device that helps deliver nutrition and medication directly to the person's stomach). Record review of Resident #37's Comprehensive Care Plan, dated 09/12/2025, reflected the resident required EBP due to his g-tube and one of the interventions was to use EBP as appropriate. Record review of Resident #37's Physician Order, dated 09/12/2025, reflected Enhanced Barrier Precautions due to PEG tube. Observation on 09/18/2025 at 11:28 AM revealed RN B was about to do Resident #37's bolus feeding via g-tube. She washed her hands, started to prepare the things needed for bolus feeding, and placed them on the resident's overbed table. She washed her hands again and put on a pair of gloves. She then proceeded with bolus feeding. She did not wear a gown before giving the resident's formula via g-tube. it was observed that there was sign outside the door that EBP was required because the resident had a g-tube. In an interview on 09/18/2025 at 11:46 AM, RN B stated Resident #37 had a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455627	A. Building B. Wing	09/19/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g-tube and EBP was required. She said she did not know why she forgot to wear a gown when she administered the resident's bolus feeding. She said the gown was needed basically to prevent transmission of microorganisms from one resident to another. She said she would wear a gown the next time she would care for residents with g-tube. In an interview on 09/19/2025 at 7:01 AM, the DON stated hand hygiene was the most effective way to prevent cross contamination and spread of infection. He said staff should do hand hygiene before and after any care. He said gloves should be changed after cleaning the resident's bottom and before touching the new brief. he said the same principle applied after touching the soiled linen. He said using a soaked towel could also contribute to infection because the germs could seep to the whole face towel even though the staff folded the face towel. He said every resident that needed EBP had a sign outside to remind the staff that they needed to wear a gown and gloves every time they had contact with the resident. He said the EBP was used to protect the spread of infection from one resident to another. He said he already initiated an in-service about infection control and would closely monitor, along with the IP, the staffs' adherence to the policy of infection control. In an interview on 09/19/2025 at 7:33 AM, ADON A stated she was the infection preventionist of the facility and she was made aware about the issues regarding infection control. She said the staff should be mindful that they were not causing any spread of infection in the facility and one way to do that was to do hand hygiene before, after, and during any care. She said the staff should change their gloves after touching soiled like soiled brief, soiled linens and even after cleaning the residents' bottom. She said another way to prevent the spread of infection was to wear EBP when needed. She said residents with g-tube required an EBP to protect the resident and also the staff if the resident had any microorganism that could cling to them. She said the DON already started an in-service and she would closely monitor if the staff were following the policy and procedure for infection control. In an interview on 09/19/2025 at 8:02 AM, the Administrator stated they always remind the staff to be vigilant with hand hygiene. She said after touching something soiled, the staff should change their gloves and sanitize the hands in between changing of gloves. She said, she was not a clinician, but she knew that if there was sign to wear EBP, then the staff should wear a gown in addition to the gloves. She said the concerns discussed would all contribute to the development and spread of infection. She said the DON already started an in-service about infection control. She said they would re-educate the staff and closely monitor so they could correct the staff on the spot. Policy and procedure for Incontinent Care was requested via email to the Administrator on 09/18/2025 at 12:09 PM and 09/19/2025 at 10:21 AM but was not provided prior to exit. Record review of the facility's policy entitled Urinary Continence and Incontinence - Assessment and Management Strategy, Delivery, Performance revised 09/2024 reflected Policy Statement: 1. The staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence . Policy Interpretation and Implementation . 2. Relevant information . f. additional information such as the type and frequency of physical assistance necessary for the resident. Record review of the facility's, undated policy Enhanced Barrier Precautions, reflected EBP are indicated for residents with any of the following . Wounds and/or indwelling medical devices . Indwelling medical device examples include feeding tubes . don gloves and gown. Record review of the facility's policy entitled Handwashing/Hand Hygiene Strategy, Delivery, Performance revised 08/2024 reflected Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections . Policy Interpretation and Implementation . 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . 7. Use an alcohol-based hand rub . h. Before moving from a contaminated body site to a clean body site during resident care . j. After contact with blood or bodily fluids . m. After removing gloves . 9. The use of gloves does not replace hand washing/hand hygiene . Applying and Removing Gloves . 1. Perform hand hygiene before applying non-sterile gloves.

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	455627	A. Building B. Wing	09/19/2025

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Denton Village by Purehealth	2500 Hinkle Dr Denton, TX 76201

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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 and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for 1 of 6 residents (Resident #46) reviewed for dignity. CNA E failed to honor Resident #46's request to adjust the straps wrapped around the resident's leg, which was holding the catheter bag in place, when she advised it was too tight. This failure placed residents at risk of not having their right to a dignified existence and self-determination maintained and led Resident #46 to feeling frustrated and ignored.Findings included: Record review of Resident #46's Face Sheet, dated 09/17/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #46 had diagnosis of urinary and flaccid neuropathic bladder (weak bladder muscles). Record review of Resident #46's Quarterly MDS Assessment, dated 09/09/25, reflected Resident #46 had a moderate cognitive impairment with a BIMS score of 12. The Quarterly MDS Assessment reflected an active diagnosis of a neurogenic bladder. Record review of Resident #46's Comprehensive Care Plan, dated 09/09/25, did reflected the resident's use of a Suprapubic urinary catheter and an intervention was the use of a catheter leg bag when the resident was in her wheelchair and participating in activities. Record review of Resident #46's Physician Order, dated 09/18/25, reflected urinary catheter draining bag. In an observation and interview on 09/17/25 at 10:51 AM, Resident #46 stated the straps around her leg, holding the catheter bag in place, were too tight. She stated she told CNA E of this repeatedly, but he told her that it was not too tight, and he needed to ensure that it would stay in place. She also stated she had told him the strap was twisted in the back, both instances made her uncomfortable. She stated she was frustrated because she felt CNA E was ignoring her concerns. Resident #46 lifted up her pant leg and showed the catheter bag with the straps attached and the straps did appear too tight on the resident, and the top strap could be observed twisted on the back portion of her leg. In an interview on 09/18/25 at 1:28 PM, CNA E stated he was at the facility nearly a year. He said Resident #46 complained to him the catheter bag straps were too tight, and the strap was twisted, but he ignored her. He stated he loosensed the strap on the leg holder whenever the resident stated it was too tight. He was shown a picture of the strap around the resident's leg, and he stated it appeared too tight and he would locate the resident to adjust the straps and untwist it. He stated the risk of the strap being too tight could stop the resident's blood flow. In an interview on 09/18/25 at 1:48 PM, LVN D stated she was employed at the facility for a month. She was told about Resident #46 complaining to CNA E about the catheter straps being too tight. LVN D was shown a picture of it by this surveyor. She stated CNA E told her this was discussed. She stated the CNA should have adjusted the straps because the resident requested it. She stated not adjusting the strap made the resident uncomfortable and could impact the resident's blood circulation. She stated the resident had not mentioned this to her today, but she did adjust it yesterday when it was brought to her attention. She stated when she observed the straps, it did appear too tight. In an interview on 09/19/25 at 11:00 AM, ADON A was told Resident #46 complained to CNA E about the catheter straps was too tight and twisted, but CNA E refused to adjust it. She stated the CNA should have adjusted the strap because the resident complained to him it was too tight for her. She stated it could cut off her blood circulation. In an interview on 09/19/25 at 11:08 AM, the DON told Resident #46 complaining to CNA E about the straps holding her catheter bag against her leg, was too tight and twisted, but CNA E refusing to adjust it. He was advised it was also observed, and the straps appeared too tight and was twisted. He stated the CNA should have adjusted the strap because the resident had complained to him it was too tight for her. He stated it was the resident's right to have it adjusted to her comfort level. Record review of facility's policy, Resident Rights, dated 08/2024, revealed Employees shall treat all residents with kindness, respect, and (continued on next page)

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	455627	A. Building B. Wing	09/19/2025

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:a. a dignified existence.b. be treated with respect, kindness, and dignity.c. be free from abuse, neglect, misappropriation of property, and exploitation.e. self-determination

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the resident's right to personal privacy during medical treatment for two (Resident #21 and Resident #37) of eight residents reviewed for resident rights. 1. The facility failed to ensure the LVN D closed Resident #21's door while checking her blood sugar on 09/18/2025 2. The facility failed to ensure RN B closed Resident #37's while providing his bolus feeding via g-tube (gastrostomy feeding tube: a tube that is surgically inserted through the skin of the belly and into the stomach) on 09/18/2025. These failures could place the residents at risk of not having their personal privacy maintained while treatment was provided. Findings included: 1. Record review of Resident #21's Face Sheet, dated 09/18/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with type 2 diabetes mellitus (high blood sugar). Record review of Resident #21's Quarterly MDS Assessment (assessment used to determine functional capabilities and health needs), dated 09/09/2025, reflected the resident was cognitively intact (resident capable of normal cognition and needs little support) with a BIMS (screening tool used to assess cognitive status) score of 15. The Quarterly MDS Assessment indicated that the resident had diabetes mellitus. Record review of Resident #21's Comprehensive Care Plan, dated 07/17/2025, reflected the resident had diabetes mellitus and one of the interventions was FSBS AC and HS with sliding scale (a chart of insulin dosages). Record review of Resident #21's Physician Order, dated 08/26/2020, reflected Humalog Solution 100 UNIT/ML (Insulin Lispro). Inject as per sliding scale: if 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units, subcutaneously (administer under the skin) before meals for Diabetes Mellitus > 400 CALL DR. Observation on 09/18/2025 at 11:09 AM revealed LVN D was about to check Resident #21's blood sugar. She sanitized her hands and then sanitized the glucometer. She inserted a test strip into the glucometer and put it inside a plastic cup. She also placed some alcohol wipes and a push button safety lancet on the plastic cup. She went inside the room and positioned herself on the resident's right side. She did not close the door nor pulled the privacy curtain while she was checking the resident's blood sugar. LVN D was facing the door and what she was doing could be seen from the hallway. After checking the blood sugar, she went back to her cart and prepared the insulin. After preparing the insulin, she went back inside the room and administered the insulin on the resident's left arm. She also did not close the door nor pulled the privacy curtain while administering the insulin. It was observed that several staff and residents were passing by the resident's room while the blood sugar was being checked and while insulin was being administered. In an interview on 09/18/2025 at 11:19 AM, LVN D stated she forgot to close the door while she was checking the resident's blood sugar and when she administered her insulin. She said the door should be closed to provide privacy during treatment or care. She said the resident might get embarrassed that other people could see what her treatments were. In an interview on 09/19/2025 at 6:54 AM, Resident #21 stated that some nurses would close her door when her blood sugar was checked or if her insulin was given but some would not. She said she got used to with the staff not closing her door, but it would be nice if her door was closed when given her insulin. 2. Record review of Resident #37's Face Sheet, dated 09/18/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing). Record review of Resident #37's Comprehensive MDS Assessment, dated 07/02/2024, reflected the resident had a moderate impairment (resident may need additional support and monitoring) in cognition with a BIMS score of 12. The Comprehensive MDS Assessment indicated the resident had a feeding tube (medical device that helps deliver nutrition and medication directly to the person's stomach). Record review of Resident #37's Comprehensive Care Plan, dated 09/01/2025, reflected the resident required tube feeding and one of the interventions was to see MD orders for current feeding orders. Record review of Resident #37's Physician Order, dated 08/15/2025, reflected Enteral Feed Order four times (continued on next page)

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	455627	A. Building B. Wing	09/19/2025

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a day for nutrition FEEDING BOLUS: Jevity 1.5 46 cc. Every 6 hours bolus/gravity per G-Tube. Document the amount of formula provided every shift. Record review of Resident #37's Physician Order, dated 08/07/2025, reflected FLUSH tube with 220 cc of additional water every 6 hours OR at the start and stop of bolus/gravity/cyclic feeding cycle every 6 hours. Observation on 09/18/2025 at 11:28 AM revealed RN B was about to do Resident #37's bolus feeding via g-tube. She washed her hands, started to prepare the things needed for bolus feeding, and placed them on the resident's overbed table. She then proceeded with bolus feeding. She did not close the door nor pulled the privacy curtain while she was giving the resident's formula. The resident was facing the hallway and several staff, visitors, and residents were passing by. It could be seen from the hallway when she raised the resident's shirt to connect the syringe to the g-tube and when she was holding the syringe up with the formula in it. While she was in the process of waiting for the bolus feeding to be done, MA G entered the resident's room and asked RN B something. She then closed the door on her way out. In an interview on 09/18/2025 at 11:40 AM, Resident #37 did not reply when asked how he felt when other people saw his g-tube. In an interview on 09/18/2025 at 11:46 AM, RN B stated she should have closed the door when she was giving Resident #37's formula. She said the door should be closed to provide privacy for the resident. She said the door should be closed every time the resident was given his bolus feeding to provide dignity and privacy. In an interview on 09/18/2025 at 11:58, MA G stated she closed Resident #37's door to provide privacy while RN B was giving resident's bolus. She said the door should be closed because sometimes the resident might get embarrassed that he had a tube connected to him. In an interview on 09/19/2025 at 7:01 AM, the DON stated the door should be closed every time the staff provided care or treatment to provide privacy. He said checking the blood sugar, administering the insulin, and doing bolus feeding were treatments done for the resident so their doors should be closed so others, like non-clinical personnel, visitors, and other residents would not see the treatments being done. He said the door should be closed or the privacy curtain pulled to avoid embarrassment. He said, aside from being embarrassed, closing the door could make the resident more comfortable during treatment. He said the expectation was for the staff to provide privacy during treatment. He said he was made aware about the issue of not closing the door during treatment and he already started an in-service regarding privacy during care. In an interview on 09/19/2025 at 7:33 AM, ADON A stated the staff should close the door when they were providing care to the residents. She said the staff need to get used to providing privacy during treatment because it could affect the resident's dignity and how they see themselves. She said it did not matter if the residents mind or not, but the expectation was for the staff should be sensible enough that if they were in the residents' position, they would not want everybody in the hallway to see what was being done to them. She said she and the DON were made aware of the issue and an in-service about closing the door during treatment was already initiated. In an interview on 09/19/2025 at 8:02 AM, the Administrator stated the staff must make sure that the residents were provided privacy when providing care to prevent awkwardness. She said it was important that the residents were provided privacy so they would be comfortable when treatment was provided. She said the expectation was for the staff to be mindful about privacy when providing treatment. She said the DON already started an in-service about privacy and they would closely monitor the staff adherence to the policy. Record review of the facility's policy entitled, Resident Rights Strategy, Delivery, Performance revised 08/2024 reflected Policy Statement: Employees shall treat all residents with kindness, respect, and dignity . Policy Interpretation and Implementation . 1. Federal and state laws guarantee certain basic rights to all residents . t. privacy and confidentiality.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 3 residents (Resident #10) reviewed for care plans. The facility failed to ensure Resident #10's usage of a nebulizer was care planned. This failure could place the residents at risk of not receiving the necessary care and services required.Findings included: Record review of Resident #10's Face Sheet, dated 09/18/25, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Relevant diagnoses included Atherosclerotic heart disease (clogged arteries). Record review of Resident #10's Quarterly MDS assessment, dated 07/27/25, reflected he had moderate cognitive impairment with a BIMS score of 8 and an active diagnosis of coronary artery disease. Record review of Resident #10's physician orders, dated 09/18/25, reflected saline nebulizer 0.9 % give 1 vial via every 4 hours, PRN. Record review of Resident #10's Quarterly Care Plan, dated 07/21/25, did not reflect a care plan for the resident's use of the nebulizer machine. In an interview on 09/18/25 at 2:15 PM, ADON A was told by the Surveyor of Resident #10 not having his use of a nebulizer care planned. She stated it should have been care planned because it was a care provided to the resident. She stated they did not currently have an MDS nurse, so it was the responsibility of the ADON, DON, and Corporate MDS nurse to ensure it was added to the resident's care plan. She stated they try to ensure that every care provided to a resident was care planned when they have their care plan meetings, but this was overlooked. In an interview on 09/19/25 at 11:08 AM, the DON was told by the Surveyor of Resident #10 had orders for the use of a nebulizer but it was not care planned. He stated the resident had orders so he did not think it should be care planned, but he stated it was a plan of care needed for the resident. He stated the MDS nurse normally updated the care plan, but the facility he currently did not have an MDS nurse, so the nursing staff should have updated the resident's care plan with this care. He stated that it was missed. He stated it was the DON, the ADON, and the corporate MDS nurse's responsibility to update the care plan. Record review of facility's policy, Care Plans, Comprehensive Person-Centered (08/2024) reflected A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan:a. includes measurable objectives and timeframes.b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including:(1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment

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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 observations, interviews, and record review the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two of three residents (Resident #10 and #11) reviewed for respiratory care. The facility failed to ensure Resident 10's nebulizer mask was properly stored in a bag when not in use on 09/17/25. The facility failed to ensure Resident 11's nasal canula was properly stored in a bag when not in use on 09/17/25. These failures could place residents at risk for respiratory infection and not having their respiratory needs met.Findings include: 1. Record review of Resident #10's Face Sheet, dated 09/18/25, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Relevant diagnoses included Atherosclerotic heart disease (clogged arteries). Record review of Resident #10's Quarterly MDS assessment, dated 07/27/25, reflected he had moderate cognitive impairment with a BIMS score of 8. Active diagnosis included coronary artery disease. Record review of Resident #10's physician orders, dated 09/18/25, reflected saline nebulizer 0.9 % give 1 vial via every 4 hours, PRN. Record review of Resident #10's Quarterly Care Plan, dated 07/21/25, did not reflect a care plan for the resident's use of the nebulizer machine. In an interview and observation on 09/17/25 at 10:31 AM, LVN D stated Resident #10 used a nebulizer on an as needed basis. LVN D observed the resident's nebulizer mask connected to the nebulizer device, on top of a 3-drawer chest, unbagged. She stated the mask should be bagged when not in use to avoid the resident getting an infection. 2. Record review of Resident #11's Face Sheet, dated 09/18/25, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with acute respiratory failure (difficulty breathing). Record review of Resident #11's Comprehensive MDS Assessment, dated 07/12/25, reflected the resident had a moderate cognitive impairment with a BIMS score of 8. The Comprehensive MDS Assessment indicated that the resident had an active diagnosis of acute respiratory failure. Record review of Resident #11's Comprehensive Care Plan, dated 07/13/25, reflected the resident received oxygen therapy and an intervention included the use of an oxygen concentrator. Record review of Resident #11's physician orders, dated 09/18/25, reflected Oxygen at 2 liters per NC treatment for hypoxia/SOB every shift. In an interview and observation of 09/17/25 at 11:06 AM, LVN D stated Resident #11 used his oxygen concentrator on an as needed basis. LVN D observed the resident's nasal canula sitting on top of the resident's bed unbagged. She stated the nasal canula should be bagged when not in use to avoid the resident getting an infection. In an interview on 09/18/25 at 2:15 PM, ADON A was told by the Surveyor of Resident #10 not having his nebulizer mask bagged when not in use, and Resident #11 not having his nasal canula bagged when not in use. She stated she had trained the staff to ensure that the nasal canula and face mask were bagged or removed when not in use. She stated not bagging them could result in the resident getting an infection. In an interview on 09/19/25 at 11:08 AM, the DON was told by the Surveyor of Resident #10 not having his nebulizer mask bagged when not in use, and Resident #11 not having his nasal canula bagged when not in use. He stated the expectation was for the devices to be placed in a bag when not in use. He stated the nursing staff should check for this when they are assessing the resident. He stated the risk of not bagging the nasal canula and mask could be the resident's getting an infection. Review of the facility's policy Oxygen Administration, 09/2024, reflected The purpose of this procedure is to provide guidelines for safe oxygen administration. 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.2. Review the resident's care plan to assess for any special needs of the resident.3. Assemble the equipment and supplies as needed.