

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2025
NAME OF PROVIDER OR SUPPLIER Denton Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3345 Medpark Dr. Denton, TX 76210	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of hazards as was possible for 1 (Resident #2) of five residents reviewed for accident hazard. The facility failed to ensure that a container of germicidal (substance that destroys germs and microorganism) wipes was not left inside Residents #2's room on 10/07/2025. This failure could prevent the residents from having an environment that was free from toxic chemicals. Findings include: Record review of Resident #2's Face Sheet, dated 10/07/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with neoplasm (abnormal growth of tissue in the body) of the esophagus (hollow tube that carries food and liquid from the throat to the stomach). Record review of Resident #2's Comprehensive MDS Assessment (assessment used to determine functional capabilities and health needs), dated 09/02/2025, 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 13. The Comprehensive MDS Assessment indicated that the resident had a medically complex condition (health issues that involves multiple chronic conditions). Record review of Resident #2's Comprehensive Care Plan, dated 07/17/2025, reflected the resident was at risk for dehydration related to cancer. The Comprehensive Care Plan indicated the resident was at risk for alteration in psychosocial well-being and one of the intervention was to observe and report any changes in mental status. During an observation and interview on 10/07/2025 at 9:54 AM revealed Resident #2 was in her bed, awake. It was observed that there was a container of germicidal wipes on the resident's white rattan table located near the resident's door. The resident said the container had been inside the room for some time and the aides were using the wipes to clean some of the items inside the room. In an interview on 10/07/2025 at 10:58 AM, LVN B stated technically, the germicidal wipes were not supposed to be inside the resident's room because they could cause various adverse effects such as skin irritation. She said she would ask the DON on what to do the germicidal wipes inside Resident #2's room. In an interview on 10/07/2025 at 11:29 AM, CNA C stated the staff used the germicidal wipes to clean the room. She said it should not be left inside the room because the wipes had chemicals that could be harmful to the residents if they were able to use them to wipe their eyes or were able to consume them. She said she did not notice the container of germicidal wipes inside Resident #2 room and did not know who left it there. She said she would give it to the nurse if it was still there. She said she would also check the other residents' rooms on her assigned hall. In an interview on 10/07/2025 at 12:08 PM, ADON A stated the container of germicidal wipes should not be inside Resident #2's room or any residents' room for that matter. She said the germicidal wipes should not be kept inside the rooms of the residents because they were not safe and should be kept inside the nurses' cart or MA's carts. She said it did not matter if the resident was confused or not, but the wipes were soaked in chemicals that could be harmful if ingested or used accidentally to wipe the eyes or used for incontinent care. She said it could result to skin irritation and eye irritation. She said the resident was immunocompromised and could have more severe reactions. She said the germicidal wipes were used to destroy microorganisms and were used with gloves on. She said the germicidal wipes should be inside the nurses' cart or the MAs' carts. She said the DON already started an in-service with regards to not leaving germicidal wipes inside the residents' rooms. In an interview on 10/07/2025 at 12:53 PM, the DON stated the germicidal wipes should not inside the residents' rooms because they have chemicals that could cause adverse effects if consumed or had contact with the skin. She said the container of germicidal wipes was closed but somebody could open it pull some wipes with their bare hand. She said the wipes were handled with gloves on because they have chemical on them to eliminate germs on surfaces. She said she was still asking who left it inside Resident #2's room so she could remind them not to leave any germicidal wipes inside the rooms of the residents. She said the container of germicidal wipes was taken out of the room and was placed inside the cart. She said she already started an in-service about not leaving any germicidal wipes inside the rooms for resident safety. In an interview on 10/07/2025 at 1:05 PM, the Administrator stated the container of germicidal wipes should not be left inside the rooms of the residents because they could take some and accidentally use them that could result to skin or eye irritation. He said the DON already started an in-service and he would personally check the rooms that there were no germicidal wines inside the room. Record review of the facility's policy entitled Storage Areas</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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 one (Residents #1) of eight residents reviewed for medication storage. The facility failed to ensure that Resident #1's collagen powder (medication used for wound care) for wound care was not inside the room on 10/07/2025. This failure could place residents at risk of misuse of medications that could lead to overdosing or underdosing. Findings include: Record review of Resident #1's Face Sheet, dated 10/07/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with pressure ulcer (wound on the skin caused by prolonged pressure to specific area of the body) of sacral (area at the bottom of the spine) region. Record review of Resident #1's Comprehensive MDS Assessment, dated 08/09/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident was at risk for pressure ulcer. Record review of Resident #1's Comprehensive Care Plan, dated 08/25/2025, reflected that the resident had a stage 4 pressure ulcer of the lower sacrum and one of the interventions was to provide treatments as per order. Record review of Resident #1's Physician's Order, dated 07/09/2025, reflected Wound care: Lower sacrum: Cleanse with NS, pat dry with gauze, apply collagen powder then silver alginate, and cover with silicone border dressing daily. During an observation and interview on 10/07/2025 at 9:49 AM revealed Resident #1 was in her bed, awake. It was observed that there was two packs of collagen powder on the resident's bedside table. The resident said the collagen powder was for wound on her bottom. She said she did not know who brought the collagen powder. During an observation and interview on 10/07/2025 at 10:58 AM, LVN B stated she was not aware there were packs of collagen powder on top of the Resident #1's side table and did not notice them when she made her round. She said the collagen powder were used for wound care and should be inside the nurse's cart or the treatment cart. She said it could be possible that the resident mistakenly consume it. She said there were no resident going inside other residents' room but it could be a possibility. She said it might cause stomach upset when consumed. She went inside the resident's room and saw the pack of collagen powder and said she would ask the DON on what to do with the packs of collagen powder inside the resident's room. In an interview on 10/07/2025 at 12:08 PM, ADON A stated medications should not be inside the residents' rooms and should be stored inside the carts. She said collagen powders were used for wound care and should be inside the nurse's cart. She said confused resident or residents with poor eyesight could eventually consume them. She said if collagen powders were consumed, they might cause allergic reactions and stomach problems. She said the staff should always scan the residents' rooms for any medications. She said the DON already started an in-service about no medications inside the rooms of the residents. In an interview on 10/07/2025 at 12:28 PM, the WCN stated the collagen powder should not be inside the Resident #1's room but inside the treatment cart. She said she did not know who left them inside the resident's room. She said she had some collagen powders inside the treatment cart that was the one she used when she cleaned the resident's wound. She said the resident could mess with it that could cause adverse effects. In an interview on 10/07/2025 at 12:53 PM, the DON stated the collagen powder must have been left by hospice because they were the one supplying collagen powder for the resident #1's wound. She said she already called hospice to let them know not to leave an medication inside the room and to give any medication to the nurse in-charged. She said the collagen powders should not be inside because they were medications and should be inside the carts. She said collagen powders were applied topically and could be harmful when ingested. She said she already started an in-service about not leaving any medication inside the rooms of the residents. In an interview on 10/07/2025 at 1:05 PM, 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. He said the residents might consume the medications inappropriately. He said the DON already started an in-service about medication storage. Record review of the facility's policy entitled MEDICATION STORAGE Pharmacy Services Policies and Procedures revised 04/17/2024 reflected POLICY . biologicals are stored safely, securely . the facility will store all drugs and biologicals in locked compartments . biological supply is only accessible to licensed nursing personnel, pharmacy personnel or authorized staff members</p>		