STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675136	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denton Rehabilitation and Nursing Center	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consult with the physician regarding a change in condition for 1 (Resident #1) of 4 residents reviewed for change of condition.The facility did not consult with Resident #1's physician about his pattern of refusing to wear his CPAP (continuous positive airway pressure machine for the treatment of sleep apnea) on 2/22/26, 2/23/26, and 2/24/26; removing his oxygen by nasal canula at times; or his low oxygen saturation on 2/25/26.These failures could place residents at risk of having delayed treatments or worsening conditions.Findings included:Review of Resident #1's face sheet reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses in part including pulmonary edema (too much fluid in the lungs), sleep apnea (repeated stops and starts in breathing during sleep), and congestive heart failure (occurs when the heart can't pump blood well enough to give the body a normal supply).Review of Resident #1's Five-Day MDS dated [DATE], reflected Resident #1 had the ability to understand others with clear comprehension, his ability to express ideas and wants (considering both verbal and non-verbal expression) was understood, and his speech was clear with distinct intelligible words. The MDS reflected no behavioral symptoms and no rejection of evaluation or care. The MDS reflected that Resident #1 required continuous oxygen therapy and CPAP. The MDS reflected a BIMS score of 11 indicating moderate cognitive impairment.Review of Resident #1's care plan dated 02/19/26, reflect Resident #1 was at risk for impaired gas exchange, respiratory distress, inflammation, and decline in pulmonary function, oxygen was to be administered per physician orders, and oxygen saturation was to be monitored every shift and as needed and abnormalities were to be reported to the physician. Further review of Resident #1's care plan reflected, Monitor oxygen saturation every shift and as needed and report abnormalities to physician (start date 2/19/26).Review of Resident #1's physician order dated 02/19/26 reflected, Apply CPAP at bedtime. Special Instructions: apply per home settings. Notify provider and DON of refusal. Twice a day. Review of Resident #1's February 2026 Medication Administration Record reflected he refused his CPAP on 02/22/26, 2/23/26, and 02/24/26 on the night shift as signed by RN A.Review of Resident #1's progress notes for the nights of 02/22/26, 02/23/26, and 02/24/26 did not reflect any incidents, harm, or decompensation related to the refusals.Review of Nursing progress note dated 02/23/26 at 07:38 by RN A reflected, Resident refused CPAP again this shift and opted for just NC to sleep with, did not sleep most of the shift, c/o pain effectively managed with PRN Hydro.Review of Resident #1's progress notes did not reflect documentation that the physician or nurse practitioner were notified of his refusal of CPAP, his removal of oxygen by nasal canula, or his low oxygen saturation on 02/25/26.During an interview on 04/01/26 at 04:40 a.m., RN A reported that Resident #1 had refused his CPAP on 02/22/26, 2/23/26, and 02/24/26 but she did not notify the physician or the DON of this refusal. She stated she had notified Resident #1's family member of the refusal. She stated she did not notify the provider because Resident #1 accepted oxygen by nasal cannula when he refused his CPAP. She stated that at times Resident #1 would remove his oxygen by nasal canula and receive redirection by staff. She stated she had received training in documenting and notifying the physician (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of changes in residents' status. She denied there were any symptoms such as oxygen desaturation or respiratory distress associated with the CPAP refusals.During an interview on o4/02/26 at 08:47 a.m., NP B stated she did not know if she was ever informed of Resident #1 having an oxygen saturation of 85% on 02/25/26 or if she had ever been informed by nursing that he was refusing his CPAP at times and removing his oxygen at times. She stated she was aware of his refusals or removals because Resident #1 had informed her and she had provided him with education on the need for using his CPAP and oxygen. She stated if a nurse had told her that he refused his CPAP she would have advised them to provide the oxygen by nasal canula.During an interview on 04/02/26 at 09:46 a.m., the Attending Physician stated that she and NP B were not notified of Resident #1 not using or removing his oxygen or refusing his CPAP at times. She stated she would have recommended the facility continue frequent monitoring and education. She denied any known harm or injury related to these events. The Attending Physician stated that she and her NP should have been notified of the low oxygen saturation (85% on 2/25/26).During an interview on 04/01/26 at 11:11 a.m., the DON stated that Resident #1 was dependent on oxygen and she had not been notified and was not aware that Resident #1 was removing or refusing his CPAP or oxygen, or that his oxygen saturation had been 85% at one point on 02/25/26. She stated Resident #1 did not experience any harm related to these incidents.During an interview on 04/02/26 at 09:00 a.m., LVN C stated that she had noted Resident #1's oxygen saturation to be 85% around 09:00 a.m. on 02/25/26. She stated she accidentally charted the time as 03:33 p.m. when she was charting at the end of the day and failed to change the time. She stated she applied his oxygen and remained with him until his oxygen saturations returned to above 90%. She stated she did not document this and indicated that while her shift ended at 02:00 p.m. she was still charting at 03:33 p.m. She stated that NP B was rounding in the building on the morning of 02/25/26 (time unknown) and that she told her in person and NP B went and assessed Resident #1 that morning. She stated she did not document this. She stated, I probably should chart different. She stated normally she would have documented what his oxygen saturations came up to and she did not know why she did not. She stated she had received teaching at the facility on the need to document and report residents' change in status.During an interview on 04/02/26 at 02:55 p.m., the DON stated that if a residents oxygen saturation had been 85% or the resident was refusing CPAP or oxygen, she expected the nurse to document the finding and use their nursing judgement to decide if they could place an intervention that raised the oxygen saturation. She stated that if the resident's oxygen saturation remained low, she expected that the nurse would notify the physician.Review of facility policy titled, Change in a Resident's Condition or Status dated 2001, reflected the nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition, a need to alter the resident's medical treatment significantly, or a refusal of treatment or medications two or more consecutive times.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain clinical records that were complete and/or accurate for 1 (Resident #1) of 4 residents reviewed for clinical records in that: -The facility did not document a nursing assessment or progress note for Resident #1 when he refused his CPAP on 02/22/26 and 02/24/26.-The facility did not document a nursing assessment or progress note for Resident #1 when his oxygen saturation was low on 02/25/26. These failures could place residents at risk for wrong or missed diagnoses and/or treatments. Findings included: Review of Resident #1's face sheet reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses in part including pulmonary edema (too much fluid in the lungs), epilepsy (brain condition causing recurring seizures), sleep apnea (repeated stops and starts in breathing during sleep), and congestive heart failure (occurs when the heart can't pump blood well enough to give the body a normal supply).Review of Resident #1's Five-Day MDS dated [DATE], reflected Resident #1 had the ability to understand others with clear comprehension, his ability to express ideas and wants (considering both verbal and non-verbal expression) was understood, and his speech was clear with distinct intelligible words. The MDS reflected no behavioral symptoms and no rejection of evaluation or care. The MDS reflected that Resident #1 required continuous oxygen therapy and CPAP. The MDS reflected a BIMS score of 11 indicating moderate cognitive impairment.Review of Resident #1's care plan dated 02/19/26, reflect Resident #1 was at risk for impaired gas exchange, respiratory distress, inflammation, and decline in pulmonary function, oxygen was to be administered per physician orders, and oxygen saturation was to be monitored every shift and as needed and abnormalities were to be reported to the physician. Further review of Resident #1's care plan reflected, Monitor oxygen saturation every shift and as needed and report abnormalities to physician (start date 2/19/26).Review of Resident #1's physician order dated 02/19/26 reflected, Apply CPAP at bedtime. Special Instructions: apply per home settings. Notify provider and DON of refusal. Twice a day. Review of Resident #1's February 2026 Medication Administration Record reflected he refused his CPAP on 02/22/26, 2/23/26, and 02/24/26 on the night shift as signed by RN A.Review of Nursing progress note dated 02/23/26 at 07:38 by RN A reflected, Resident refused CPAP again this shift and opted for just NC to sleep with, did not sleep most of the shift, c/o pain effectively managed with PRN Hydro.Review of Resident #1's progress notes did not reflect documentation that the physician or nurse practitioner were notified of his refusal of CPAP, his removal of oxygen by nasal canula, or his low oxygen saturation on 02/25/26.During an interview on 04/01/26 at 04:40 a.m., RN A reported that Resident #1 had refused his CPAP on 02/22/26, 2/23/26, and 02/24/26 but she did not notify the physician or the DON of this refusal. She stated Resident #1 did not have any symptoms such as oxygen desaturation or respiratory distress associated with the CPAP refusals, but she had not charted this assessment. She did not state why she did not chart the assessment. She stated she had received training in documenting and notifying the physician of changes in residents' status.During an interview on 04/02/26 at 09:00 a.m., LVN C stated that she had noted Resident #1's oxygen saturation to be 85% around 09:00 on 02/25/26. She stated she accidentally charted the time as 03:33 p.m. when she was charting at the end of the day and failed to change the time. She stated she applied his oxygen and remained with him until his oxygen saturations returned to above 90%. She stated she did not document this and indicated that while her shift ended at 02:00 p.m. she was still charting at 03:33 p.m. She stated that NP B was rounding in the building on the morning of 02/25/26 (time unknown) and that she told her in person and NP B went and assessed Resident #1 that morning. She stated she did not document this. She stated, I probably should chart different. She stated normally she would have documented what his oxygen saturations came up to and she did not know why she did not. She stated she had received teaching at the facility on the need to document (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and report residents' change in status.During an interview on 04/02/26 at 02:55 p.m., the DON stated that if a residents oxygen saturation had been 85% or the resident was refusing CPAP or oxygen, she expected the nurse to document the finding and use their nursing judgement to decide if they could place an intervention that raised the oxygen saturation. She stated that if the resident's oxygen saturation remained low, she expected that the nurse would notify the physician.Review of facility policy titled, Change in a Resident's Condition or Status dated 2001, reflected The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.