

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/28/2024
Form Approved OMB
No. 0938-0391

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 04/04/2024
NAME OF PROVIDER OR SUPPLIER Denton Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2229 N Carroll Blvd Denton, TX 76201	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for two (Resident #45 and Resident #29) of ten residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #45 and Resident #29's rooms was in a position that was accessible to the resident. This failure could place the residents at risk of being unable to obtain assistance when needed and not to get help in the event of an emergency. Findings included: Resident #45 Review of Resident #45's Face Sheet dated 04/02/2024 reflected that resident was a 53 -year-old male admitted on [DATE]. Relevant diagnoses included muscle weakness, acquired hammer toes (abnormal bending of the toe), and difficulty in walking. Review of Resident #45's Quarterly MDS assessment dated [DATE] reflected Resident #45 was cognitively intact with a BIMS score of 15. Resident #45 required supervision for bed mobility, transfer, eating, and toilet use. Review of Resident #45's Comprehensive Care Plan dated 01/25/2024 reflected Resident #45 was at risk for falls and one of the interventions was to increase staff supervision with intensity based on resident need. No intervention noted to put the call light within reach. Review of Resident #45's Comprehensive Care Plan dated 01/25/2024 indicated Resident #45 was unable to perform ADL Functions independently due to NWB (non-weight bearing) status and the interventions were to assist with transfer, assist with repositioning, and assist with ADLs. No intervention noted to put the call light within reach. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with Resident #45 on 04/02/2024 at 9:25 AM revealed resident on his bed, resting. It was noted that the resident's call light was behind the side table of his roommate. When asked where his call light was, the resident searched for it on his side. The resident verbalized he cannot find it. The resident stood up and started to walk towards where the call lights were connected to the wall and started to pull the call light from the back of the table and placed it on the recliner located in front of the roommate's side table. Resident #45 added he did not usually use the call light but in cases of emergencies, he might not be able get up and walk to get to the call light. Observation on 04/02/2024 at 11:17 AM revealed RN E was preparing to give Resident #45's medication. RN E went inside the room to administer the medication. After giving the medication, RN E went out of the room and did not notice the call light was not within reach of Resident #45. Resident #29 Review of Resident #29's Face Sheet dated 04/02/2024 reflected that resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included history of falling, muscle weakness, and difficulty in walking. Review of Resident #29's Quarterly MDS assessment dated [DATE] reflected that Resident #29 had a moderate cognitive impairment with a BIMS score of 10. Resident #29 required supervision for bed mobility, transfer, eating, and toilet use. Review of Resident #29's Comprehensive Care Plan dated 03/14/2024 reflected resident was at risk of injury related to falls and one of the interventions was to ensure call light was in reach and answer promptly. The Comprehensive Care Plan also indicated resident had falls on the 09/06/2023, 10/18/2023, and 03/13/2024. Observation on 04/02/2024 at 9:35 AM revealed Resident #29 was on her bed sleeping. It was noted that the resident's call light was behind the side table of the resident's roommate. Observation and interview with RN E on 04/02/2024 starting at 11:53 AM, RN E stated call lights were important and should be with the residents at all times because these were what the residents used to let the staff know they needed something. RN E said the call lights were used by the residents to call the attention of the staff, if they needed help to go to the restroom, or a refill on their water pitcher. If the call lights were far from the residents, the residents might try to do the activity themselves, and fall in the process. RN E went inside Resident #45's room and took the resident's call light from the recliner and placed it on the resident's bed. RN E then went inside Resident #29's room and tried to pull the resident's call light but was not able to pull it. RN E said the call light was stuck. RN E moved the side table forward to be able to pull the call light and place it on Resident #29's bed. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with CNA A on 04/02/2024 at 1:45 PM, CNA A stated the call light should be with the residents all the time whether the resident was dependent or not. CNA A said they needed the call light to call the staff if they needed something or were in distress. She added, Resident #45 was independent, but in cases of emergencies, it might be difficult for him to stand up and look for his call light. CNA A said the staff still needed to ensure the call light was with resident #45. CNA A then stated Resident #29 was the one making her bed. She said the call light could have fallen while she was making the bed and got stuck behind the side table located at the end of her bed. CNA A continued that if the call light was stuck behind the table on the other side, it would be hard for the resident to get the call light. CNA A said the staff should also ensure the call light was accessible even though Resident #29 was the one fixing her bed. CNA A added the staff should monitor if the call light were with the residents all the times they were inside the room. In an interview with CNA C on 04/03/2024 at 9:40 AM, CNA C stated call lights were particularly important for the residents. CNA C said the resident needed the call light to ask for assistance or help. In addition, CNA C said if the residents could not reach the call light, the resident could not communicate their needs to the staff. CNA C said the residents might get mad, frustrated, or could start yelling to get the attention of the staff. CNA C said she would make a round to check if the call lights were with the residents. In an interview with the DON on 04/04/2024 at 8:42 AM, the DON stated the call lights were significant to the residents. The DON said the call lights were important because this was one way to keep the residents safe. She said the call lights were also provided to be a means of communication between the residents and the staff. She added the resident used the call lights if they needed help or if they needed assistance. The DON further added there should be a conscious effort from the staff to place the call lights where the residents could reach them. She said it was not an excuse to say the resident was independent and not monitor the call light. She explained if the independent resident had an emergency, the resident might not be able to stand up to look for his call light. For other residents, they might fall if they try to stand up because nobody was there to assist them. The DON said the expectation was for the staff to continue their rounds to make sure the call lights were within reach of all the residents. The DON said she would continue to educate the staff through an in-service about the significance of call lights being accessible to the residents. In an interview with the Administrator on 04/04/2024 at 9:40 AM, the Administrator stated call lights must always be with the residents so the residents could alert the staff if they needed something, if they were not feeling well, if they were in pain, or if there was an emergency. If the residents did not have their call lights, the residents would not be able to communicate their needs. The Administrator said the expectation was that the staff were to do more rounds and make sure the call lights were within the reach of the residents. The Administrator said they would continue to remind the staff for proper placement of the call lights. Record review of the facility's policy Answering the Call Light MED-PASS, Inc. revised September 2022 revealed, Purpose: The purpose of this procedure is to ensure timely responses to the resident's request and needs . General Guidelines . 4. Ensure that the call light is accessible to the resident .		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47743 Based on observation, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at S483.10(c)(2) and S483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for a resident for three of (Resident # 14, Resident #48, and Resident #75) of six residents reviewed for Care Plans. The facility failed to ensure Resident #14 and Resident #75 were care planned for oxygen administration. The facility failed to ensure Resident #48 was care planned for CPAP (continuous positive airway pressure: machine used to deliver pressurized air through a mask to keep airways open). These failures could place residents at risk of respiratory needs not being met. Findings included: Resident # 14 Review of Resident #14's Face Sheet dated 04/02/2024 reflected that resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and acute respiratory failure with hypoxia (low level of oxygen in the blood). Review of Resident #14's Quarterly MDS assessment dated [DATE] reflected that Resident #48 had a moderate impairment in cognition with a BIMS score of 11. The Quarterly MDS also indicated that the resident was on oxygen therapy. Review of Resident #14's Comprehensive Care Plan dated 02/05/2024 reflected resident had no plan of care for oxygen supplement. Review of Resident #14's Physician Order dated 03/04/2022 reflected, oxygen @ 2-3 LPM via nasal cannula prn for dyspnea/low O2 sats. Observation on 04/02/2024 at 9:36 AM revealed Resident #14 was on her bed, sleeping. It was noted the resident had an oxygen concentrator at bedside. Interview with Resident #14 on 04/03/2024 at 7:26 AM, Resident #14 revealed she had been on oxygen for a long time but cannot specifically remember the date she started on oxygen. Resident #14 said she did not have it always. Resident #48 (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #48's Face Sheet dated 04/02/2024 reflected that resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included chronic respiratory failure with hypoxia (low level of oxygen in the blood) and chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs) . Review of Resident #48's Quarterly MDS assessment dated [DATE] reflected that Resident #39 had a moderate impairment in cognition with a BIMS score of 12. The Quarterly MDS also indicated that the resident was on oxygen therapy. No diagnosis for sleep apnea (a sleep disorder where breathing is interrupted repeatedly during sleep) noted. Review of Resident #48's Physician Order for CPAP dated 01/22/2024 revealed CPAP on Q HS. Review of Resident #48's Comprehensive Care Plan dated 02/05/2024 reflected resident had no plan of care for CPAP. Observation on 04/02/2024 at 9:47 AM revealed Resident #48 was on her bed awake. It was also noted that there was no CPAP machine placed on the resident's side table. Interview with Resident #48 on 04/03/2024 at 7:43 AM, Resident #48 confirmed she was using a CPAP when she was admitted to the facility. Resident #48 added she did not want to use it anymore because it was uncomfortable. Observation and interview with RN E on 04/04/2024 at starting at 7:47 AM, RN E stated she was not aware the resident was on CPAP. RN E checked if there was an order and confirmed there was an order for CPAP. RN E then checked if there was a care plan for CPAP. RN E acknowledged there was no care plan for CPAP. RN E then reviewed Resident #48's progress notes and read that resident was refusing the CPAP. RN E said there should be a care plan for CPAP since she was admitted with a CPAP. RN E added there should also be a care plan if the resident was refusing to use her CPAP. RN E said the care plan should reflect the resident's usage and refusal to CPAP so the staff could provide proper or alternative interventions. RN E said if there was no care plan, the staff would not know the needed interventions and what to assess. Resident #75 Review of Resident #75's Face Sheet dated 04/02/2024 reflected that the resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included acute respiratory failure with hypoxia, pneumonia (inflammation and fluid in the lungs caused by a bacterial, viral, or fungal infection), and emphysema (a lung disease that damages the air sacs in the lung causing shortness of breath). Review of Resident #75's Quarterly MDS assessment dated [DATE] reflected that Resident #27 had a severe impairment in cognition with a BIMS score of 07. The Quarterly MDS also indicated that the primary reason for admission was respiratory failure. Review of Resident #75's Comprehensive Care Plan dated 03/07/2024 reflected no care planned for oxygen administration. Review of Resident #75's Physician Order dated 01/02/2023 reflected, oxygen @ 2 - 3 LPM via nasal cannula for dyspnea/low O2 sats. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/02/2024 at 9:59 AM revealed Resident #75 was not inside her room. It was also noted that the resident had an oxygen concentrator at bedside. A nasal cannula was attached to the oxygen concentrator and the prongs of the nasal cannula was on the floor. The nasal cannula was not bagged. Observation on 04/02/2024 at 11:36 AM revealed Resident #75 was rolled out of the room to the nurse station. RN E then put an oxygen tank behind the wheelchair. A nasal cannula was connected to the oxygen tank and the other end was placed to the resident's nostril. In an interview with Resident #75 on 04/03/2024 at 7:36 AM, Resident #75 stated she had been on oxygen since last year. She said when she was inside the room, she would use the oxygen box but when she was outside of her room, she would use the tank situated behind her wheelchair. In an interview with RN E on 04/03/2024 at 7:58 AM, RN E stated the care plan was primarily an overview of the resident's care. RN E said the staff needed the care plan to know the medical issues and they needed interventions for such. RN E added without the care plan, there might be confusion about the care of the resident, and it could cause medication error if medications were involved. She added that without the care plan, the staff would not know the resident's needs at that time resulting in needs not being met. She said if a resident had an active diagnosis regarding any respiratory issues and had an order for oxygen, there should be a care plan for an oxygen supplement. RN E checked Resident #48 and Resident #75's care plan and found no care plan for an oxygen supplement. Interview and observation with MDS Nurse F on 04/04/2024 at 8:07 AM, MDS Nurse stated care plans were important because it directed the plan of care for the residents so the nurses would know what to do. She said the care plan should correspond to the diagnosis and physician orders. MDS Nurse F added the care plan was there to help address the medical needs of the residents. She said without the care plan, the staff would not be able provide the particular needs of the resident. She added the residents would still be cared for but not on their specific needs. MDS Nurse F said nurses should coordinate and communicate when they see any changes on the resident. MDS Nurse F checked Resident #14 and Resident #75's care plan and saw no care plan for oxygen supplement. MDS Nurse then checked Resident #48 care plan and saw no care plan for CPAP nor no care plan for noncompliance. She acknowledged that there was oversight because the care plans were not provided for some of the residents. In an interview with the DON on 04/04/2024 at 8:42 AM, the DON stated the purpose of the care plan was to know the resident's needs and for the staff to know what kind of care and interventions were needed. She said without the care plan, the staff would not know the needed care and assistance the residents required. The DON said MDS nurses do the care plan, but nurses should observe, assess, and coordinate with management if there was an issue that was noted. She added there was an oversight that the care plan for oxygen supplement and CPAP were not done. The DON said she would continue to educate the staff through an in-service about the significance of a care plan. The DON concluded that moving forward, she will monitor staff's observance to the policy care planning to ensure the best possible care. In an interview with the Administrator on 04/04/2024 at 9:40 AM, the Administrator stated the care plan was important to provide care with consistency. He said every medical issue of the residents should be care planned. The Administrator said that without a care plan, the resident would not have the care needed and required. The Administrator concluded that the expectation was that the staff would ensure every resident was care planned. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility's policy, Care Planning - Interdisciplinary Team 2001 MED - PASS, Inc. revised March 2022 revealed 1. Resident care plans are developed according to the timeframes and criteria . 2. Comprehensive, person-centered care plans are based on resident assessments.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan was reviewed and revised by an interdisciplinary team for one (Resident #77) of six residents reviewed for revised Care Plan. The facility failed to ensure Resident #77's care plan was revised to reflect discontinued use of tube feeding. This failure could place the resident at risk of current needs not being met. Findings included: Review of Resident #77's Face Sheet dated 04/03/2024 reflected that the resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included stomatitis (inflammation of the mouth and lips) and dysphagia (difficulty in swallowing). Review of Resident #77's Comprehensive Care Plan dated 01/03/2024 reflected Resident #77 was still on tube feeding. Review of Resident #77's Comprehensive MDS assessment dated [DATE] reflected the resident was not able to complete the interview to determine the BIMS score. The Comprehensive MDS Assessment also indicated resident was on mechanically altered diet and did not reflect that Resident #77 was on feeding tube. Review of Resident #77's Comprehensive Care Plan dated 01/03/2024 reflected Resident #77 was still on tube feeding. Review of Resident 77's Physician Order on 04/03/2024 reflected no order for enteral (delivery of food and medications through a tube in the stomach) feeding. Review of Resident #77's Progress Note dated 04/28/2023 reflected, . G-tube had been dc (discontinued) by physician . Observation on 04/02/2024 at 9:25 AM revealed Resident #77 was on his bed sleeping. It was also noted that there was no IV pole with feeding formula hanging at bedside. Observation and interview with Resident #77 on 04/03/2024 at 8:06 AM revealed that Resident #77 was sitting at the side of his bed eating breakfast. Resident #77 denied he was on tube feeding. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with RN E on 04/03/2024 at starting at 8:16 AM, RN E stated Resident #77 was not on tube feeding. RN E went to the resident's orders and said there were no orders for enteral feeding. RE N then looked over the resident's care plan and said there was still a care plan for tube feeding. RN E said she would verify with her manager and then would resolve the care plan. RN E said if the resident was not on tube feeding anymore, the care plan should had been updated to show the present health condition of the resident. If the care plan was not updated, there could be a confusion on the care of the residents and the residents might not receive the treatment needed. In an interview with MDS Nurse F on 04/04/2024 at 8:07 AM, MDS Nurse F stated the care plan should reflect the plan of care needed by a resident at the present. MDS Nurse F said if the resident was not on tube feeding anymore, it should not be on the care plan anymore. She said this should had been communicated to the MDS Nurse so the care plan was updated. She said the care plan should be updated to assess if the goals were met or not met and then make appropriate changes for the interventions as needed. In an interview with the DON on 04/04/2024 at 8:42 AM, the DON stated if a resident was not on tube feeding anymore, goals and interventions for tube feeding should not be reflected on the care plan of the resident. The DON said the care plan should reflect the current care being given to the resident. The DON said if tube feeding was already discontinued, it should had been communicated to the DON or the MDS Nurse so the care plan would have been updated timely. The DON further said if the care plan of the residents were not updated, there could be confusion about the residents' care or some of the care would be missed. The DON said the expectation was for the residents to be properly assessed and communicate any pertinent changes to update the care plan if needed. The DON concluded she would do an in-service with regards to the revising the care plan. Interview with the Administrator on 04/04/2024 at 9:40 AM, the Administrator stated every resident should have a care plan that was accurate in order to provide care with consistency. The Administrator said the care plan should reflect the current needs of the residents. The Administrator said the expectation was the care plans would be updated as needed. Record review of facility policy, Care Plan, Comprehensive Person-Centered Nursing Services Policy and Procedure Manual for Long-term Care, 2001 MED-PASS revised March 2022 revealed, Policy Statement: A comprehensive, person-centered care plan . implemented for each resident . Policy Interpretation and Implementation . 12. The interdisciplinary team reviews and updates the care plan.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to ensure that Residents, who needed respiratory care, was provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for four (Resident #77, Resident #14, Resident #48, and Resident #75) of ten residents reviewed for respiratory care. The facility failed to ensure Resident #77 and 48's nebulizer masks were properly stored. The facility failed to ensure Resident #14 and Resident 75's nasal cannulas were properly stored. These failures could place the residents at risk for respiratory infection and not having their respiratory needs met. Findings included: Resident # 77 Review of Resident #77's Face Sheet dated 04/03/2024 reflected that resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included pneumonia and pneumonitis (inflammation of the lung tissues). Review of Resident #77's Comprehensive MDS assessment dated [DATE] reflected resident was not able to complete the interview to determine the BIMS score. Review of Resident 77's Physician Order on dated 12/31/2022 reflected, ipratropium-albuterol solution for nebulization; 0.5 mg - 3mg (2.5 mg base)/3 mL; amt: 1 vial; inhalation. Every 6 Hours - PRN Observation on 04/02/2024 at 9:25 AM revealed Resident #77 was on his bed sleeping. It was also noted that his nebulizer mask was sitting on the recliner parallel to his bed. The mask used for the nebulizer was not bagged. Resident # 14 Review of Resident #14's Face Sheet dated 04/02/2024 reflected that resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included chronic obstructive pulmonary disease and acute respiratory failure with hypoxia. Review of Resident #14's Quarterly MDS assessment dated [DATE] reflected that Resident #48 had a moderate impairment in cognition with a BIMS score of 11. The Quarterly MDS also indicated that the resident was on oxygen therapy. Review of Resident #14's Comprehensive Care Plan dated 02/05/2024 reflected resident had no plan of care for oxygen supplement. (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #14's Physician Order dated 03/04/2022 reflected, oxygen @ 2-3 LPM via nasal cannula prn for dyspnea/low O2 sats Observation on 04/02/2024 at 9:36 AM revealed Resident #48 was on her bed, sleeping. It was noted resident had an oxygen concentrator at bedside. A nasal cannula was connected to the oxygen concentrator. The nasal cannula was hanging on top of the concentrator and was not bagged. Resident # 48 Review of Resident #48's Face Sheet dated 04/02/2024 reflected that resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease. Review of Resident #48's Quarterly MDS assessment dated [DATE] reflected that Resident #39 had a moderate impairment in cognition with a BIMS score of 12. The Quarterly MDS also indicated that the resident was on oxygen therapy. Review of Resident #48's Physician Order dated 01/22/2024 revealed oxygen @ 4 LPM via nasal cannula continuous. Review of Resident #48's Comprehensive Care Plan dated 01/14/2024 reflected resident had SOB/wheezing related to COPD and one of the interventions was to provide medications per physician orders. Observation on 04/02/2024 at 9:47 AM revealed the resident was on her bed, awake. It was also noted that her breathing mask used for the nebulizer was on the drawer. The breathing mask was not bagged. Resident # 75 Review of Resident #75's Face Sheet dated 04/02/2024 reflected that the resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included acute respiratory failure with hypoxia, pneumonia, and emphysema. Review of Resident #75's Quarterly MDS assessment dated [DATE] reflected that Resident #27 had a severe impairment in cognition with a BIMS score of 07. The Quarterly MDS also indicated that the primary reason for admission was respiratory failure. Review of Resident #75's Comprehensive Care Plan dated 03/07/2024 reflected no care planned for oxygen administration. Review of Resident #75's Physician Order dated 01/02/2023 reflected, oxygen @ 2 - 3 LPM via nasal cannula for dyspnea/low O2 sats. Observation on 04/02/2024 at 9:59 AM revealed Resident #75 was not inside her room. It was also noted that the resident had an oxygen concentrator at bedside. A nasal cannula was attached to the oxygen concentrator and the prongs of the nasal cannula were on the floor. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with RN E on 04/02/2024 at 11:56 AM, RN E stated the breathing mask, and the nasal cannula should not have been exposed nor touching anything because it could cause infections. RN E said the breathing mask and the nasal cannula should have been bagged when not in use. RN E went inside Resident #77's room and saw the breathing mask on the recliner. RN E disconnected the breathing mask and said she would get a new one and would put it in a plastic bag. RN E then went to Resident #14's room and disconnected the nasal cannula attached to the oxygen concentrator. RN E then proceeded to Resident #48' room and disconnected the breathing mask. Lastly, RN E went to Resident #75's room and disconnected the nasal cannula from the oxygen concentrator. She said she would go get some breathing masks and nasal cannulas to replace those that she disconnected. In an interview with the DON on 04/04/2024 at 8:42 AM, the DON stated the breathing mask, and the nasal cannula should be bagged when not in use. The DON said it was the proper way to store the breathing mask and the nasal cannula. She said if those breathing apparatus were not bagged, exposed, or touching surfaces that were not clean, then oxygen administration could be compromised. The DON said the staff, including her, were responsible for monitoring that the apparatus used in oxygen therapy were bagged when not in use. She said the expectation was the breathing mask and the nasal cannula would be stored properly. The DON said she would continually remind the staff to be diligent in making sure the procedures for respiratory care were followed. In an interview with the Administrator on 04/04/2024 at 9:40 AM, the Administrator stated the breathing masks and the nasal cannulas should be stored properly to prevent potential respiratory infections. The Administrator said the expectation was for the staff to be diligent in providing respiratory care in order to provide the highest level of care. Record review of facility's policy, Departmental (Respiratory Therapy) - Prevention of Infection 2001 MED-Pass, Inc. revised November 2011 revealed Purpose: the purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment . Steps in the Procedure . 8. Keep the oxygen cannula and tubing used PRN in a plastic bag when not in use.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49459 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in (1 of 1) kitchen reviewed for dietary services., in that: 1) Dietary staff failed to seal, label, and date refrigerator and freezer food items . 2) Dietary staff failed to remove items which have frost built up inside the container (bag). These failures could place residents at risk for food contamination and foodborne illness. The findings included: Inside the freezer on the left side of the door, had one case of breaded frozen chicken tenders that were open, leaving the patties exposed to contaminants and cold. Inside the freezer on the right of the door, had a stainless-steel bin which contained a gallon size bag of boneless pork chops. The pork chops were heavily freezer-burned, which would indicate a quality issue of the food item(s). During an interview with the Dietary Manager on 04/02/2024, between 9:30 a.m. and 10:05 a.m., a walk-through of the facility kitchen was performed, and the Dietary Manager confirmed the State Surveyor observations. The Dietary Manager confirmed he was responsible for kitchen sanitation and proper storage of food products and that the deficient practices were oversights. The Dietary Manager stated if items in the freezer were not sealed or stored properly, they could get freezer burn which would make it inedible . The Dietary Manager said he has worked at this facility for 4 years, [AGE] years in the food service industry. He said that all food items stored in the dry storage area and freezer should be secured in airtight packages and labeled with use by date or date opened. The DM stated if items in the freezer were not sealed or stored properly, they could get freezer burn which would make it inedible. He said foods stored incorrectly could be contaminated by pests or cause illness due to spoilage. On 04/10/2024 at 3: 20 PM a copy of the Facility safety policy for Food Storage and Labeling was requested and none was provided prior to survey team exit. Review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. 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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based observations, interviews, and record review, the facility failed to 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 one (Resident #1) of five residents observed for infection control. The facility failed to ensure that CNA B changed her gloves and performed hand hygiene while providing incontinence care to Resident #1. This failure could place the residents at risk of cross-contamination and development of infection. Findings included: Review of Resident #1's Face Sheet dated 04/03/2024 reflected resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included diarrhea, urinary tract infection, and a rash. Review of Resident #1's Comprehensive MDS assessment dated [DATE] reflected Resident #1 was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated Resident #6 was always incontinent for bowel. Review of Resident #1's Care Plan dated 02/07/2024 reflected resident had incontinence of bowel and one of the interventions was change promptly and apply a protective barrier to skin. Observation and interview on 04/03/2024 starting at 9:40 AM revealed Resident #1 was on her bed awake. CNA B told Resident #1 that she would be changing her. CNA B prepared the things needed for incontinent care. CNA B washed her hands and put on gloves. CNA B then unfastened the tape on both sides of the brief, rolled the front half of the brief down, and then pushed it between the resident's thighs. CNA B cleaned the front part of the resident using the front to back technique. CNA B instructed and assisted the resident to turn to the right. When the resident was on the side lying position, the resident begun to have a bowel movement. CNA B waited for the resident to finish. When the resident was done with the bowel movement, CNA B cleaned the resident. After wiping down the resident, CNA B rolled the rest of the brief, pulled it, and threw it in the trash can. CNA B then proceeded to get the new brief, opened it, and placed it at the bottom of the resident. CNA B did not change her gloves nor wash/sanitize her hands. The resident was assisted to the lying position. CNA B fastened the tape on both sides, pulled the blanket up, and gave the call light and cell phone charger to the resident. CNA B took off her gloves and threw them in the trash can. CNA B said she washed her hands before and after doing incontinent care. CNA B acknowledged she did not change her gloves after cleaning the resident and touching the soiled brief. She said she should have taken off her gloves, washed her hands or sanitized her hands, and then put on new gloves after cleaning the resident and before getting the new brief. She added this could result to cross contamination and infection because the microorganisms from the soiled gloves could transfer to the things touched after incontinent care. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN D on 04/03/2024 at 9:57 AM, LVN D stated the right procedure was to wash her hands and change the gloves after cleaning the bottom of the resident and before getting the new brief. She said the purpose of the method was to prevent contamination and infection. She said microorganisms could easily transfer if the gloves were not changed throughout incontinent care. She added microorganisms could transfer from the soiled gloves to everything they would touch while wearing the same gloves used for incontinent care. She said she would educate CNA B on the importance of changing gloves during incontinent care. In an interview with the DON on 04/04/2024 at 8:42 AM, the DON stated she was made aware about the infection control issue during incontinent care. The DON said the gloves should have been changed after cleaning the buttocks of the resident. Not changing the gloves could result in cross contamination and infection. The DON added it was important to wash hands and change gloves during incontinent care because dirty gloves would contaminate the clean briefs. The DON said the expectation was the staff would remember to wash their hands and change their gloves when transitioning from a dirty area to a clean area. The DON said she already did a one-on-one in-service with CNA B but would do an infection control in-service for all the staff. She concluded that she would continually remind the staff to be attentive to the procedures for infection control. Interview with the Administrator on 04/04/2024 at 9:40 AM, the Administrator stated the gloves should be changed when cleaning the residents to prevent infection. He said he would remind the staff during staff meetings to be mindful about the procedures followed pertaining to infection control. The Administrator concluded that the expectation was for the staff to be diligent in whatever they do in order to provide the highest level of care. Record review of facility's policy, Incontinent Care revealed Policy: To provide quality nursing care and provide personal hygiene in incontinent residents requiring perineal care . Procedure . 5 . Take wet wipes . using wipe . only once wipe from font to the back . and then discard wipe and gloves. 6. Reapply fresh non contaminated gloves.		