

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675281	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2025
NAME OF PROVIDER OR SUPPLIER Cottonwood Creek Healthcare Community		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 W Shore Dr Richardson, TX 75080	

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)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>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 (Resident #1 and Resident #2) of five residents reviewed for Respiratory Care.</p> <p>1. The facility failed to ensure Resident #1's nasal canula (flexible tube used to deliver oxygen to the nose through two prongs) at the back of her wheelchair was properly stored when not in use on 04/22/2025.</p> <p>2. The facility failed to ensure Resident #2's breathing mask for his nebulizer (a medical device that turns liquid medicine into mist that could be inhaled through a face mask) and CPAP (continuous positive airway pressure: machine used to deliver pressurized air through a mask to keep airways open) mask were properly stored when not in use on 04/22/2025.</p> <p>These failures could place residents at risk for respiratory infection and not having their respiratory needs met.</p> <p>Findings included:</p> <p>1. Record review of Resident #1's Face Sheet, dated 04/22/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs).</p> <p>Record review of Resident #1's Quarterly MDS Assessment, dated 03/10/2025, reflected the was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated the resident was on oxygen therapy.</p> <p>Record review of Resident #1's Quarterly Care Plan, dated 03/16/2025, reflected the resident had chronic obstructive pulmonary disease and one of the interventions was to use of oxygen therapy as ordered.</p> <p>Record review of Resident #1's Physician orders, dated 12/14/2025, reflected Oxygen every shift for O2 dependence @ 3 LPM via nasal cannula.</p> <p>(continued on next page)</p>

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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 04/22/2025 at 9:36 AM revealed Resident #1 was in her bed, awake. The resident was on oxygen administration via nasal cannula at 3 liters per minute. The nasal cannula was attached to an oxygen concentrator. It was observed that the resident had a portable oxygen tank at the back of her wheelchair with a nasal cannula attached to it. The nasal cannula was not bagged and the prongs of the nasal cannula was touching the left brake of the wheelchair Resident #1 said she used the nasal cannula on the wheelchair everytime she would go out of the room.</p> <p>Observation and interview on 04/22/2025 at 9:57 AM, LVN B stated the nasal cannula should be bagged everytime Resident #1 was not using it to prevent infection. She went inside the room and saw a nasal cannula attached to the portable oxygen tank behind the resident's wheelchair. She observed that the nasal cannula was not bagged and was touching the left brake of the wheelchair. She disconnected the nasal cannula and threw it in a trash can. She said she would get a new nasal cannula and a plastic bag for it. She said she would also let the charge nurse of the hall what was observed.</p> <p>2. Record review of Resident #2's Face Sheet, dated 04/22/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with respiratory failure and obstructive sleep apnea (a sleep disorder where breathing is interrupted repeatedly during sleep).</p> <p>Record review of Resident #2's Quarterly MDS Assessment, dated 04/06/2025, reflected the resident was cognitively intact with a BIMS score of 14. The Quarterly MDS Assessment indicated the resident had respiratory failure and obstructive sleep apnea.</p> <p>Record review of Resident #2's Comprehensive Care Plan, dated 01/13/2025, reflected the resident had oxygen therapy related to respiratory failure and one of the interventions was to administer medications as ordered. Comprehensive Care Plan also indicated the resident had sleep apnea and one of the interventions was to apply CPAP at night and remove in the morning.</p> <p>Record review of Resident #2's Physician Orders, dated 03/10/2025, reflected the following:</p> <p>*Ipratropium-Albuterol Inhalation Solution 0.5 - 2.5 (3) MG/3ML (Ipratropium-Albuterol) 1 vial inhale orally two times a day for Wheezing.</p> <p>* Start CPAP every night. Please have family bring in patient's home CPAP machine and use former settings. at bedtime related to OBSTRUCTIVE SLEEP APNEA.</p> <p>Observation and interview on 04/22/2025 at 10:14 AM, revealed Resident #2 was in his bed, awake. It was observed that the resident was using oxygen at 2 liters per minute. He said he had been using oxygen for some time but could not remember for how long. He said he also received breathing treatment daily and used CPAP at night. He said he was not aware where the staff put his breathing mask and CPAP mask after they took it off. The resident's breathing mask was observed on top of the side table and the CPAP mask was inside the resident's drawer. Both masks were not bagged.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview with LVN A on 04/22/2025 at 10:18 AM, LVN A stated he was made aware by LVN B about Resident #1's nasal cannula. He said he did not notice it when he did his morning round. He said the nasal cannula should be in a bag when the resident was not using it to prevent infection. He said he would also remind the aides that whenever they transfer the resident, they should put the nasal cannula inside a bag or call him so he could store the nasal cannula properly. LVN A then went inside Resident #2's and saw the breathing mask on top of the table and the CPAP mask inside the drawer. He said he would get a new breathing mask to replace the one on the table. He said he would get plastic bags for the breathing mask and the CPAP mask. He said he would clean the CPAP mask first before putting it inside the plastic bag. He said both the breathing mask and the CPAP mask should be bagged to prevent infection.</p> <p>In an interview on 04/22/2025 at 12:49 PM, the DON stated the nasal cannula, the breathing mask, and the CPAP mask were supposed to be in a bag when the residents were not using them to prevent cross contamination and worsening of any respiratory issues the residents might already have. She said the expectation was for the staff to be mindful and make sure all the respiratory paraphernalia were bagged and kept clean. She said she would conduct an in-service about respiratory care immediately after the interview.</p> <p>In an interview on 04/22/2025 at 12:56 PM, the Administrator stated everything that the residents use to supplement their breathing should be kept clean to prevent cross contamination and possible infection. She said, for this incident, the expectation was for the staff to bag the nasal cannula, breathing mask, and CPAP mask when not in use. She said she would coordinate with the DON to educate and re-educate the staff about the respiratory care issue. She said the facility do not have a policy specific for bagging the nasal cannula, breathing mask, and CPAP mask.</p> <p>Policy for bagging the nasal cannula, breathing mask, and CPAP mask requested verbally on 04/22/2025 at 12:56 PM but was not provided prior to exit.</p>		