

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675292	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/29/2026
NAME OF PROVIDER OR SUPPLIER  Cottonwood Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  2224 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of accident hazards as was possible for accident prevention for 1 of 4 resident halls (Hall 3) observed for safety hazards. The Maintenance Director failed to ensure his toolbox was closed and secure from residents gaining access to it on Hall 3. This failure could result in the residents accessing the toolbox and using tools to potentially harm themselves or others. Findings include: In an observation on 01/29/26 at 09:06 AM, a large toolbox was observed open at the end of Hall 3, unsecured. The toolbox exposed numerous tools, such as a cordless drill, screwdrivers, wrenches, and a hammer, which may be harmful to a resident. Residents were observed entering and exiting their rooms, and one resident was observed wandering the hall. In an observation and interview on 01/29/26 at 9:08 AM, the Administrator was shown the unsecured opened toolbox. She stated maintenance was using the toolbox to make repairs. She stated the toolbox should not have been left unsecure because it was a safety concern for residents. In an interview on 01/29/26 at 11:37 AM, the Maintenance Director was informed of his toolbox being left on the hall unsecured. He stated the Administrator spoke with him about leaving his toolbox out. He stated the toolbox needed to be secured because it could be a trip hazard and the tools in his toolbox could harm a resident. The facility's policy Resident Rights (undated) reflected The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide--1. A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.a. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675292	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/29/2026
NAME OF PROVIDER OR SUPPLIER  Cottonwood Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  2224 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)		
<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record reviews the facility failed to ensure that residents, who needed respiratory care, were provided care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of four residents (Resident #1) reviewed for respiratory care. The facility failed to ensure Resident #1's nasal canula was properly stored in a bag when not in use on 01/06/26. This failure could place the resident at risk for respiratory infection and not having his respiratory needs met. Findings included: Record review of Resident #1's Face Sheet, dated 01/29/26, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had acute respiratory failure with hypoxia (low oxygen intake). Record review of Resident #1's Quarterly MDS Assessment, dated 12/19/25, reflected Resident #1 had an intact cognitive response. The Quarterly MDS Assessment reflected the resident had an active diagnosis of respiratory failure. Record review of Resident #1's Physician Orders, dated 01/29/26, reflected Oxygen LPM: 2-4 L via nasal canula as needed for acute respiratory failure. In an observation and interview on 01/29/26 at 9:13 AM, Resident #1 was observed in the hallway in his wheelchair. A nasal canula was observed sitting on top of his bed, unbagged. The resident stated he only used the oxygen device at night and had not used it since getting out of bed this morning. In an observation and interview on 01/29/26 at 9:15 AM, LVN A was shown Resident #1's nasal canula sitting on top of his bed unbagged. She stated the night nurse should have bagged the nasal canula to avoid the nasal canula from contamination. She stated the resident used oxygen at night, but he sometimes used it during the day. She stated it was the nurse's responsibility to ensure the nasal canula was bagged when not in use. In an interview on 01/29/26 at 9:55 AM, the Regional Nurse was informed of Resident #1's nasal canula not being bagged and she stated it should have been bagged when not in use. She stated not bagging it could result in the resident getting an infection. She stated it was the nurse's responsibility to ensure the nasal canula was bagged. In an interview on 01/29/26 at 01:32 PM, the ADON stated she was told about Resident #1 not having his nasal canula bagged when not in use. She stated it needed to be bagged to prevent him getting an infection. She stated it was the nurse's responsibility to ensure it was bagged once when he was not using it. Review of the facility's policy Oxygen Administration, 10/2010, 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 any special needs of the resident.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675292	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/29/2026
NAME OF PROVIDER OR SUPPLIER  Cottonwood Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  2224 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)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure that residents' food and drink was palatable, attractive, and at a safe and appetizing temperature for 37 of 39 residents on regular, mechanical, or pureed diets. The Dietary Manager failed to ensure the residents' meals were at a safe and appetizing temperature. This failure could result in the residents consuming food at unsafe temperatures and experiencing unhealthy weight loss. Findings included: In an interview on 01/29/26 at 10:30 AM, Resident #2 stated she was the Resident Council President and for the past 6 months, she and the residents who attended the meeting were complaining about the food being served for all meals. She stated the main concern was the food was always cold. She stated she had provided this feedback to the Dietary Manager. In an interview and observation on 01/29/26 at 12:30 PM, the Dietary manager provided a test tray of a regular, mechanical, and pureed diet. The food was lukewarm. The DM stated she sometimes checked to ensure the cook was checking the temperature of the food as it was prepared, but she did not check it regularly. She stated she received the temperature logs from the cooks at the end of the day but was not present when the temperature was taken. She stated if the food was too cold, residents would not want to eat, and they would lose weight. The DM could not provide a temperature log for the breakfast and lunch meals served on 01/29/26. In an interview on 01/29/26 at 1:30 PM, the outgoing Administrator was informed of the complaint about the temperature of the food. She stated she spoke with the DM and found out the warming plate was malfunctioning, and they would get it repaired. She was informed of the DM stating she did not monitor the cooks to ensure they were checking the temperature of the food. She stated she would ensure the kitchen was checking the temperature of the food prior to it being dispersed to the residents to ensure it was meeting the preferable temperature for residents. She stated she had never received any feedback about the food being cold. In an interview on 01/29/26 at 2:56 PM, the incoming Administrator stated she was made aware of the concerns with the temperature of the food being cold by the Outgoing Administrator and the DM. She stated they were in the process of in-servicing the kitchen staff on ensuring the food was at the correct recommended temperature and they will get operational warming plates. In an interview on 01/29/26 at 2:56 PM, [NAME] C stated he had been at the facility for 4 months. He stated he usually got the temperature of the food when he removed it from the stove, and the food was well over the required temperature of 165. He stated the temperature of the cooked food was not verified by anyone, he just turned the temperature information at the end of his shift. He stated he was never instructed on when to check the temperature of the food. Record review of the facility's temperature logbook on 01/29/26, reflected no temperature log for breakfast and lunch served to residents on 01/29/26. The facility's policy Resident Rights (undated) reflected The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy.</p>		