STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675292	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottonwood Nursing & Rehabilitation	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for two residents (Resident #1 and Resident #2) reviewed for abuse and neglect.The facility failed to ensure Resident #2 was free from abuse on 6/21/26, when Resident #1 approached Resident #2 in the smoking area and hit Resident 2 in the face. No injuries were observed.This failure could place residents at risk of abuse and physical harm.Findings include: 1. Record review of Resident #1's face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: Schizoaffective disorder, Delusional disorder, Dementia, hostility, cognitive communication deficit, and other psychoactive substance use. These diagnoses indicated impaired judgment, altered thought processes, impaired cognition, and the potential for aggressive or impulsive behaviors. Record review of Resident #1's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 15, indicating the resident was cognitively intact. Record review of Resident #1's care plan dated 02/09/2026 reflected interventions to continually monitor for behaviors and adverse effects of medications and notify the physician or nurse practitioner as required. The care plan directed staff to document behaviors and medication side effects weekly and each shift, implement resident-centered interventions to reduce behaviors, and verbally report any observed behaviors or medication side effects to a licensed nurse. Record review of Resident #1's progress note dated 06/21/2026 indicated that while residents were outside in the smoking area, Resident #2 looked at Resident #1, and Resident #1 became upset. Documentation reflected Resident #1 stood up and pushed Resident #2's head into the wall. The residents were immediately separated, Resident #1 was placed on one-to-one supervision, and psychiatric services were contacted. Documentation further reflected an order obtained to transfer Resident #1 to an inpatient psychiatric facility for evaluation. Record review of Resident #1's progress note dated 06/21/2026 reflected Resident #1 was observed on the telephone with his family member screaming and yelling. Documentation indicated Resident #1 was extremely agitated, red in the face, and recounting the incident from outside, telling his family member exactly what he had done. The nurse documented concerns for the safety of Resident #1 and the safety of other residents. Record review of Resident #1's progress note dated 06/22/2026 reflected Resident #1 was observed at the nurses' station and stated, I'm being transferred to another facility because I smashed Resident #2's head into the wall, but he deserved it. Documentation reflected Resident #1 continued to acknowledge his actions and demonstrated a lack of remorse for the incident. 2. Record review of Resident #2's face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included moderate dementia with agitation, mild cognitive impairment, cognitive communication deficit, active primary progressive multiple sclerosis, and anxiety disorder. These diagnoses indicated impaired cognition, impaired communication, and the potential for altered awareness of events. Record review of Resident #2's Quarterly MDS dated [DATE] reflected a BIMS score of 07, indicating Resident #2 was severely cognitively impaired. Record review of Resident #2's care plan dated 09/24/2025 reflected interventions directing staff to (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide resident-centered interventions to reduce behaviors, continually monitor for behaviors and medication adverse effects and notify the physician or nurse practitioner as required, analyze key times, places, circumstances, triggers, and interventions that de-escalate behaviors, and notify the charge nurse of any abusive behaviors. Record review of Resident #2's nursing progress note dated 06/21/2026 reflected Resident #2 was outside in the smoking area when Resident #1 became upset after Resident #2 looked at him. Documentation reflected Resident #1 pushed Resident #2's head into a wall. The residents were immediately separated, and Resident #2 was assessed from head to toe. No injuries were observed, and Resident #2 denied pain. Documentation further reflected a skull X-ray series was initiated as a precaution with negative results. Resident #2 stated that Resident #1 hit him, causing his head to strike the wall. Record review of Resident #2's social services progress note dated 06/21/2026 reflected the social worker interviewed Resident #2 regarding the resident-to-resident altercation. Documentation reflected Resident #2 stated he was doing alright, reported the incident did not bother him, denied being fearful, denied head pain, and stated he felt okay before proceeding to an unrelated conversation. Record review of Resident #2's discharge progress note dated 06/30/2026 reflected Resident #2 was transported to another facility with his personal belongings, medications, order summary, and discharge paperwork. Interview with Family Member #1 on 07/01/2026 at 12:00 p.m. revealed he was aware of the resident-to-resident altercation involving Resident #1. Family Member #1 stated Resident #1 had a long history of psychiatric illness and impulse control deficits and believed the incident occurred while Resident #1's psychiatric medications were being adjusted. Family Member #1 stated Resident #1 perceived Resident #2 was staring at him, which contributed to the altercation in conjunction with Resident #1's mental illness and impulse control deficits. Family Member #1 reported Resident #1's condition had improved following the medication adjustments and stated he had no concerns regarding the care provided by the facility or its staff. Interview with CNA A on 07/01/2026 at 12:10 p.m. revealed the resident-to-resident altercation occurred during an evening smoke break. CNA A stated Resident #1 told Resident #2 that he was looking at him in a bad way. CNA A stated Resident #1 then approached Resident #2 and slapped him in the face. CNA A reported Resident #2 appeared afraid and shaken following the incident and slid down in his chair. CNA A stated she called for assistance, helped Resident #2, and the residents were immediately separated. CNA A stated she had not previously observed Resident #1 become physically aggressive toward another resident but had observed Resident #1 make rude comments to others. CNA A stated Resident #1 did not threaten Resident #2 prior to the incident but instead told Resident #2 to stop looking at him before striking him. Interview with Family Member #2 on 07/01/2026 at 12:18 p.m. revealed an initial telephone call was placed, and a return call was received shortly thereafter. Family Member #2 stated Resident #2 had been transferred to another facility. Family Member #2 reported the facility notified her of the resident-to-resident altercation that occurred in June involving Resident #2. Family Member #2 stated she believed the facility handled the incident appropriately by notifying her and did not believe the facility caused the altercation. Family Member #2 stated she was glad Resident #2 had transferred to another facility and hoped he would do well in his new placement. Interview with the Social Worker on 07/01/2026 at 12:28 p.m. revealed she was not present when the resident-to-resident altercation occurred. The Social Worker stated Resident #1 had been experiencing increased agitation prior to the incident but had not previously displayed physical aggression toward other residents and was typically able to be redirected. The Social Worker stated Resident #2 had a history of aggressive behaviors toward staff. She stated she believed Resident #2 may have been staring at Resident #1 prior to the altercation but did not witness the incident. Interview with the DON on 07/01/2026 at 12:40 p.m. revealed Resident #2 had a history of aggressive behaviors, including striking a staff member and throwing coffee on another resident. DON stated Resident #1 had a history of verbal outbursts and had refused medications in the past but had not previously displayed physical aggression toward residents. DON stated she was informed that the resident-to-resident altercation (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	occurred during a scheduled smoke break after Resident #2 looked at Resident #1, and Resident #1 struck Resident #2, causing Resident #2's head to hit the wall. DON stated Resident #1 reportedly threatened the nurse who intervened following the altercation. DON reported the residents were immediately separated, Resident #1 was placed on one-to-one supervision, and Resident #2 underwent skull X-rays, which were negative, and was placed on neurological checks. Interview with Resident #3 on 07/01/2026 at 1:00 p.m. revealed she witnessed the resident-to-resident altercation during the 7:00 p.m. smoking break on 06/21/2026. Resident #3 stated Resident #2 was seated in his wheelchair wearing sunglasses and was looking in the direction of Resident #1 while mumbling under his breath, which she stated was typical behavior for Resident #2. Resident #3 stated Resident #1 asked Resident #2 why he was looking at him and appeared agitated but did not make any verbal threats. Resident #3 stated Resident #1 then stood up and slapped Resident #2 without warning. Resident #3 stated the incident appeared unprovoked and staff immediately intervened and separated the residents. Interview with the Administrator on 07/01/2026 at 1:20 p.m. revealed Resident #2 had a history of behaviors, particularly surrounding smoking, and had previously displayed aggression toward staff and another resident. The admin stated Resident #2 required close supervision during smoking breaks due to these behaviors. The Administrator stated she was informed Resident #2 did not provoke the incident and that Resident #1 became upset because he believed Resident #2 was looking at him. The Administrator stated Resident #1 had no prior history of physical aggression toward other residents and was typically redirectable, even when experiencing psychiatric symptoms. The Administrator stated following the altercation, Resident #1 was placed on one-to-one supervision, agreed to an inpatient psychiatric evaluation, and was transferred from the facility to a psychiatric hospital the following day. At the time of the interview Resident #1 was still in the psychiatric hospital. The admin stated she counseled Resident #1 that someone looking at him was not a reason to place his hands on another resident. Interview with the Corporate Nurse on 07/01/2026 at 1:33 p.m. revealed she was notified of the resident-to-resident altercation when it occurred. The Corporate Nurse stated she was informed Resident #1 became upset during a scheduled smoking break and struck Resident #2. The Corporate Nurse stated she was familiar with Resident #1 due to his history of psychiatric symptoms but was not aware of any prior physical aggression toward other residents. The Corporate Nurse stated Resident #2 had a history of resident-to-resident and resident-to-staff aggression and had been involved in previous incidents as the aggressor. The Corporate Nurse stated the facility had been pursuing an alternative placement for Resident #2 prior to the incident due to his behavioral history Record review of the facility's undated Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy revealed that residents have the right to be free from abuse, neglect, exploitation, and misappropriation of property. The policy indicated that the facility is responsible for protecting residents from abuse by anyone, including other residents, and for identifying, investigating, and reporting all allegations of abuse. The policy requires implementation of interventions to prevent recurrence and ensure resident safety during and after investigations.