

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 07/11/2024
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</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 the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for two (Resident #23 and Resident #26) of nineteen residents reviewed for reasonable accommodation of needs.</p> <p>The facility failed to ensure the call light system in Resident #23 and Resident #26's rooms were in a position that was accessible to the residents.</p> <p>This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.</p> <p>Findings included:</p> <p>Resident #23</p> <p>Review of Resident #23's Face Sheet, dated 07/09/2024, reflected that resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included lack of coordination and weakness.</p> <p>Review of Resident #23's Quarterly MDS Assessment, dated 05/01/2024, reflected Resident #23 had a moderate impairment in cognition with a BIMS score of 09. Resident #23 was dependent to staff for toileting, shower, dressing, and personal hygiene.</p> <p>Review of Resident #23's Comprehensive Care Plan, dated 07/07/2024, reflected Resident #23 was at risk for falls related to deconditioning due to CVA (cerebrovascular accident: stroke) with hemiparesis (weakness on one side of the body) and one of the interventions was to be sure the call light was within reach.</p> <p>Observation and interview with Resident #23 on 07/09/2024 at 9:15 AM revealed Resident #23 was in her bed, awake. Resident #23's call light was observed on the floor and under the bed of the resident. Resident #23 tried to search for her call light because she said she needed to be changed. Resident #23 stated she could not even find the cord of the call light to pull it. She said the staff should put her call light where she could reach it because it was hard for her to move.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview with CNA A on 07/09/2024 at 11:11 AM, CNA A stated it was important that the call lights were placed near the residents. CNA A said the call lights should always be with the residents because the residents used them to call the staff if they needed something. CNA A said if the call lights were not with the resident, the resident would not be able to tell the staff what they needed. CNA A said the resident might be needing to be changed and she would not know. She said the resident might be frustrated, mad, or might fall if the call light was far from her. CNA A looked for Resident #23's call light and found it on the floor under the bed. CNA A knelt down, pulled the call light from the bottom of the bed, and placed it near the resident. CNA A said she did a quick tour at the beginning of her shift but did not notice that the call light was not with Resident #23. CNA A added she did not make sure the call light was with the resident after she was done with the resident's incontinent care.</p> <p>Resident #26</p> <p>Review of Resident #26's Face Sheet, dated 07/09/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included cerebral infarction (blockage in the blood vessels of the brain) and anxiety disorder.</p> <p>Review of Resident #26's Quarterly MDS Assessment, dated 05/27/2024, reflected Resident #26 had a moderate cognitive impairment with a BIMS score of 09. Resident #26 required maximal assistance for shower, dressing, and personal hygiene.</p> <p>Review of Resident #26's Comprehensive Care Plan, dated 07/06/2024, reflected Resident #26 was at risk for falls r/t to impaired mobility and one of the interventions was to be sure my call light is within reach.</p> <p>Observation and interview with Resident #26 on 07/10/24 at 7:14 AM revealed the resident was lying in bed, awake. Resident #26 said he just woke up. The resident's call light was observed on the floor. Resident #26 said he was looking for his call light but could not find it. Resident #26 said it was important that he had his call light because he usually was in bed and dependent on the staff for almost everything. Resident #26 added the staff should place the call light near his functioning hand.</p> <p>Observation and interview with LVN B on 07/10/2024 at 8:24 AM revealed LVN B entered Resident #26's room to check his blood pressure. LVN B stated the call light was on the floor. LVN B said she did not notice the resident's call light was on the floor when she did her shift change round. LVN B picked up the call light and placed it where the resident could reach it. LVN B said it was important for the call light to be within reach, so the residents could be helped when they needed assistance or help. LVN B said if the call lights were not with the residents, the residents might fall or the staff would not know the residents were having an emergency. She said she was responsible in ensuring the call lights were within reach for her assigned residents.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with DON on 07/11/2024 at 8:10 AM, the DON stated call lights were very important for the residents. The DON said the call lights were the only way of communication between the residents and the staff. The DON said the residents were also encouraged to use the call lights to call for assistance, like if they needed to go to the bathroom or needed to be turned. He said the call lights were also used by the resident if they needed something, like pain medication, refill of water, or to turn the lights off. The DON said without the call lights, the needs of the residents would not be known and would not be addressed. He added, without the call lights the needed care would not be provided. The DON said the expectation was for the staff would be mindful that every time they leave the resident's room, the call lights were with the residents. The DON said he would conduct a whole-house in-service about the call lights because the call lights were everybody's responsibility. He said the in-service would be for the nurses, CNAs, housekeeping, therapists, and management. He said he would personally monitor that all the residents' call light were within reach.</p> <p>In an interview with the ADON on 07/11/2024 at 8:39 AM, the ADON stated the call lights should not be on the floor or in a place where the residents could not reach it. The ADON said the call light must be within reach of the residents at all times because they use the call light to let the staff know they needed something. The ADON said if the call lights were far from the residents, the residents would not be able to call the staff and their needs would not be addressed. The ADON said the resident might even had a fall if they try to go to the bathroom by themselves because they could not call the staff. The ADON said the expectation was for all the staff to make sure the call lights were within the reach of all the residents. The ADON said they would do an in-service about call lights being accessible to the residents.</p> <p>In an interview with the Administrator on 07/11/2024 at 8:49 AM, the Administrator stated the call lights should not be far from the residents. The Administrator said the call lights were used by the residents to call the attention of the staff if they needed something. The Administrator said the residents might be having an emergency and staff would not know. The Administrator said the staff should be sensible about call light placement. The Administrator said they would re-educate the staff regarding call lights and would constantly remind them that before leaving the room, make sure the call lights were with the resident.</p> <p>Record review of facility's policy Resident Rights Social Services Manual 2003, revealed We believe each resident has a right to a dignified existence . and communication with and access to persons and services inside and outside our facility . Each resident is treated with consideration . care for personal needs.</p> <p>Record review of facility's policy Perineal Care Female Nursing Policy and Procedure Manual 2003 rev December 8. 2009, revealed K. Closing steps . e. Always replace call signal and needed items within resident's reach.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>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 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 two of (Resident #16 and Resident #20) eight residents reviewed for Care Plans.</p> <ol style="list-style-type: none"> The facility failed to ensure Resident #16 was care planned for smoking. The facility failed to ensure Resident #20 was care planned for hospice and enteral Feeding. <p>These failures could place the residents at risk of not receiving necessary care and services.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of Resident #16's Face Sheet, dated 07/10/2024, reflected that resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included seasonal allergic rhinitis and shortness of breath. <p>Review of Resident #16's Quarterly MDS Assessment, dated 06/06/2024, reflected that Resident #16 had a severe impairment in cognition with a BIMS score of 03.</p> <p>Review of Resident #16's Safe Smoking Assessment, dated 07/04/2024, reflected the resident knew the location of the designated area for smoking and the resident could go the designated area independently.</p> <p>Observation and interview on 07/10/2024 at 8:28 AM revealed that Resident #16 was rolling her wheelchair on the hallway going towards the smoking area. Resident #16 said she was going out for a smoke.</p> <p>In an interview with Resident #16 on 07/10/2024 at 10:16 AM, Resident #16 stated she was a smoker and had been since when she was younger. The resident said she stopped for a couple of months but went back to smoking again.</p> <p>Review of Resident #16's Comprehensive Care Plan on 07/10/2024 reflected that Resident #16 had no care plan for smoking.</p> <ol style="list-style-type: none"> Review of Resident #20's Face Sheet, dated 07/09/24, reflected resident was a 77- year-old female admitted on [DATE]. Relevant diagnosis included cognitive communication deficit and dysphagia (difficulty in swallowing) <p>Review of Resident 20's Comprehensive MDS Assessment, dated 05/29/2024, reflected resident was unable to complete the interview to determine the BIMS score. The Comprehensive MDS Assessment indicated the resident was on tube feeding and was receiving hospice care while a resident of the facility.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #20's Physician's Order, dated 06/10/2024, reflected every shift Fibersource HN or equivalent 70 ml/hour continuously. Stop for ADLs and restart immediately.</p> <p>Review of Resident #20's Physician's Order, dated 05/10/2024, reflected Hospice to evaluate and treat.</p> <p>Review of Resident #20's Care Plan on 07/09/2024 reflected Resident #20 had no care plan for tube feeding and hospice care.</p> <p>Observation on 07/09/2024 at 9:44 AM revealed Resident #20 was in her bed sleeping. The resident was connected to a feeding formula at approximately 600 ml and was running at a feed rate of 70 ml per hour.</p> <p>Observation on 07/11/2024 at 7:40 AM revealed Resident #20 was in bed, awake. Resident #20 had a feeding formula hanging from an IV pole. The feeding formula was not connected to the resident.</p> <p>In an interview with the Senior MDS Case Manager on 07/10/2024 at 11:39 AM, the Senior MDS Case Manager stated care plans were important to ensure the residents were getting the care needed. The Senior MDS Case Manager said care plans served as guide on how the staff will take care of the residents. The Senior MDS Case Manager said care plans were comprised of the problem lists, the goals, and the interventions appropriate to the needs of the residents. The Senior MDS Case Manager added that without the care plans, the staff could miss out significant interventions needed by the residents. The Senior MDS Case Manager said if a resident was a smoker, there should be care plan for smoking. She added if a resident was on tube feeding, there should be a care plan for tube feeding. She also said if a resident was admitted to hospice, there should be a care plan for hospice. The Senior MDS Case Manager logged onto her computer, searched for Resident #16's profile and said the resident did not have a care plan for smoking. She said she would add a care plan for smoking. After adding the care plan for smoking for Resident #16, the Senior MDS Case Manager said the Social Worker was responsible in making the care plan for smoking. She said the Social Worker was new and she should have oriented the Social Worker with regards to the care plan that she needed to do. She said she would talk to the Social Worker about the care plan for smoking. The Senior MDS Case Manager then went to Resident #20's profile and said the resident did not have a care plan for tube feeding and for hospice. The Senior MDS Case Manager said she would go ahead and add the care plan for both. After adding the care plan for tube feeding and hospice, she said she would audit the care plans of the residents. She said the staff and management discussed every morning if there was any changes about the residents. She said there was an oversight on her part.</p> <p>In an interview with DON on 07/11/2024 at 8:10 AM, the DON stated every resident needed a comprehensive care plan to make sure the residents receive the appropriate care needed. The DON said the care plan should be in place so that the staff providing care would be in the same page. The DON said the care plan served as a communication tool for all individuals caring for the residents. He said the care plan should be comprehensive and should show what specific care the resident needed. He said the expectation was for all residents to have a complete and detailed care plan. He said he was responsible in checking if the care plans of the residents were comprehensive and in accordance with the current condition of the residents. He said he would coordinate with the ADON, the Senior MDS Case Manager, and the Social Worker to audit the care plans.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with the ADON on 07/11/2024 at 8:39 AM, the ADON stated she was still learning how to do the care plans. The ADON stated it was important that residents have a care plan to fully provide the care and services the residents needed. The ADON said that for these cases, there should be a care plan for smoking, tube feeding, and hospice care. She added without the care plan, the current needs of the resident would not be addressed.</p> <p>In an interview with the Administrator on 07/11/2024 at 8:49 AM, the Administrator stated all the residents should have a care plan appropriate to their needs. She said without the care plan, the staff would not know the goals and the interventions needed by the residents. The Administrator concluded that the expectation was for the staff will ensure that every issue of the residents were care planned. She said she would coordinate with the DON and the Senior MDS Case Manager to make sure all the residents were care planned accordingly.</p> <p>In an interview with the Social Worker on 07/11/2024 at 11:38 AM, the Social Worker stated she did not know she was supposed to do the care plan for smoking, mood and behavior, and code status. She said that now that she knew, she would review and audit the care plans appropriately. She said the Senior MDS Case Manager told her that she would orient her about care planning.</p> <p>Record review of facility's policy, Comprehensive Care Planning, Nursing Policy & Procedure Manual, The facility will develop and implement a comprehensive person-centered care plan for each resident . that includes measurable objectives and timeframes . the resident's goals for admission and desired outcome . address the resident's medical . needs . Interventions are the specific care and services that will be implemented.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents ' choices for 1 (Resident #10) of 6 resident reviewed. for quality of care.</p> <p>The facility failed to obtain physician's orders and assess Resident #10 for a scoop mattress prior to installing the scoop mattress.</p> <p>This failure could prevent the resident to from being free of any physical harm .</p> <p>Findings included:</p> <p>Record review of Resident #10's Face Sheet, dated 07/09/2024, revealed she was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included unspecified dementia (memory decline), lack of coordination, and repeated falls.</p> <p>Record review of Resident #10's Quarterly Minimum Data Set (MDS) dated [DATE] revealed, she had a Brief Interview for Mental Status (BIMS) score of 04 (severe cognitive impairment) and for ADL care the MDS reflected, for transfers, toileting, and bathing, the resident required moderate assistance.</p> <p>In an Interview and observation on 07/10/24 at 10:45 AM with RN M, she stated she was the floor nurse for the North Hall. She observed the scoop mattress Resident #10 was lying on and stated that the resident did have physician's orders for the scoop mattress. She checked the resident's physician's orders and stated that there were physician orders in the system of record for the resident; however, the orders were dated for 07/10/24, which was after the concern was presented. RN M admitted that the orders were just recently submitted, and she stated that physician's orders were needed to ensure that the scoop mattress was not a risk to the resident and be a form or restraint for the resident.</p> <p>An interview on 07/11/24 at 11:00 AM with the DON, he stated he had been the DON at the facility for the past several months. He stated RN M had advised him of Resident #10 having a scoop mattress but no physician's orders. He stated it was overlooked but they had since made the correction and have a signed physician order for the scoop mattress. He stated the risk of the resident having the scoop mattress without a physician assessment or orders could result in the resident injuring herself.</p> <p>Record review of facility policy on Physician orders, dated 08/2007, stated It is the policy of this facility to ensure that no resident is placed in physical restraints for the purpose of discipline or convenience and that restraints are only applied to treat the resident's medical symptoms. All residents requiring physical restrains will be assessed for least restrictive measures prior to restraint application and restraints will be reduced as appropriate to the resident's medical condition. No resident will have a physical restraint placed for positioning purposes unless there is clearly no other alternative.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>Based on observation, interview, and record review the facility failed to ensure residents who are fed by enteral means received the appropriate treatment and services to prevent complications of enteral (intake of food through a tube in the gastrointestinal tract) feeding for one (Resident #20) three residents reviewed for gastrostomy tube management.</p> <p>The facility failed to ensure that LVN B checked Resident #20's G-tube (Gastrostomy tube: A tube directly inserted through the skin to the stomach to deliver nutrition) placement prior to medication administration.</p> <p>The facility failed to ensure that LVN B checked Resident #20's residual (amount of liquid remaining in the stomach) before administering medications via gastrostomy tube.</p> <p>These failures could place residents who receive enteral feedings by G-tube at risk for injury, aspiration into the lungs (fluid or food enter the lungs accidentally), decreased quality of life, hospitalization and decline in health.</p> <p>Findings include:</p> <p>Review of Resident #20's Face Sheet, dated 07/09/24, reflected resident was a 77- year-old female admitted on [DATE]. Relevant diagnosis included cognitive communication deficit and dysphagia (difficulty in swallowing).</p> <p>Review of Resident 20's Comprehensive MDS Assessment, dated 05/29/2024, reflected resident was unable to complete the interview to determine the BIMS score. The Comprehensive MDS Assessment indicated resident was on tube feeding while a resident of the facility.</p> <p>Review of Resident #20's Care Plan on 07/09/2024 revealed that the resident did not have a care plan for tube feeding.</p> <p>Review of Resident #20's Physician's Order, dated 05/23/2024, reflected Every shift Check placement prior to feeding and medication administration.</p> <p>Review of Resident #20's Physician's Order, dated 05/23/2024, reflected every shift Check residual before medications and feedings; return contents after each check.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 07/11/2024 at 7:40 AM revealed Resident #20 was in bed, awake. Resident #20 had a feeding formula hanging from an IV pole. The feeding formula was not connected to the resident. LVN B prepared the resident's medication. LVN B prepared three medications and put them in three separate plastic cups. LVN B then crushed the medications one-by-one and put them back in three small plastic cups. LVN B donned (put on) a gown and a pair of gloves. LVN B went inside the room, set the medications on the side table, and told the resident what she was going to do. LVN B went to the bathroom to get some water for flushing. LVN B put some water in the medications. LVN B started to stir the medications with the tip of the syringe. After mixing the medications, LVN B pulled the plunger of the syringe, attached the tip of the syringe to the g-tube, flushed the g-tube with 60 ml of water, and poured the dissolved medication into the syringe attached to the g-tube one at a time. LVN B flushed the g-tube with 5 ml of water after every medication administration. After giving the medication, LVN B flushed the g-tube and then connected the g-tube to the formula and turned it on. LVN B did not check for placement of the g-tube before administering the medication. LVN B did not check for the residual before administering the medications.</p> <p>In an interview with LVN B on 07/11/2024 at 8:05 AM, LVN B stated it was important to check the placement of the g-tube before feeding or medication administration to ensure the g-tube was in the correct position. LVN B said it was also important to check the gastric residual to make sure the stomach was emptying effectively. She said she was not able to check for the placement and for the residual when she gave Resident #20's medication. She said she sometimes checked for both when she disconnected the g-tube. She said she should always check for both before giving the medications. She said she did a competency check-off for enteral feeding but forgot to do both. She said if the placement was not checked, it could cause harm to the resident. She added that if the residual was not checked, the resident could suffer from aspiration pneumonia.</p> <p>In an interview with DON on 07/11/2024 at 8:10 AM, the DON stated it was important to check for the placement of the g-tube to ensure the g-tube was in the proper place. He said placement was checked before feeding or medication administration to be sure it was not clogged or displaced. He said the residual was checked also to see if the stomach was not having any intolerance to feeding. He said not checking the placement of the g-tube and the gastric residual could result to vomiting and aspiration pneumonia. He said the expectation was for the staff to check the placement of the g-tube and gastric residual before every feeding, before every medication administration, and every shift. He said he would re-educate LVN B about the proper procedure of enteral feeding. He said he would also do an in-service to all the staff doing enteral feeding.</p> <p>In an interview with the ADON on 07/11/2024 at 8:39 AM, the ADON stated the g-tube placement was always checked to make sure it was in the right place. She said even though it was checked in the morning, it should still be checked at noon. She said checking for placement could be done by using a stethoscope or by checking the residual. She said the gastric residual was also checked to make sure the stomach was not full. She said not checking the residual could result to vomiting and aspiration. She said she would coordinate with the DON on what to do about the issue.</p> <p>In an interview with the Administrator on 07/11/2024 at 8:49 AM stated the staff should follow the g-tube orders. She said if the orders said to check for placement and residual before giving medications, the staff should check for placement and residual before giving the medications. She said both were included in the procedure to provide safety for residents with a g-tube. She said she would collaborate with the clinicians to do in-service about g-tubes.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility's policy Gastrostomy Tube Care Nursing Policy & Procedure Manual 2003 rev. March 02, 2021 revealed Goals . 1. The resident will maintain nutritional status ,, Procedure . 7. Perform intermittent feeding . a. check for placement by aspiration or injecting air and listening to the stomach for sounds . b. Aspirate for gastric contents .</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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, was provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for three (Residents #26, #30, and Resident #189) of eight residents reviewed for Respiratory Care.</p> <ol style="list-style-type: none"> The facility failed to ensure an Oxygen In Use sign was placed outside of Resident #26's room. The facility failed to ensure Resident #189's mask for CPAP (continuous positive airway pressure: machine used to deliver pressurized air through a mask to keep airways open) was properly stored. The facility failed to ensure Resident #30's oxygen mask was properly stored. <p>These failures could place the residents at risk for respiratory infection and not having their respiratory needs met.</p> <p>Findings included:</p> <p>1. Review of Resident #26's Face Sheet, dated 07/09/2024, reflected that resident was a [AGE] year-old male 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 (insufficient amount of oxygen in the body).</p> <p>Review of Resident #26's Comprehensive MDS Assessment, dated 05/27/2024, reflected the resident had a moderate impairment in cognition with a BIMS score of 08. The Comprehensive MDS Assessment indicated Resident #26 was on oxygen therapy while a resident of the facility.</p> <p>Review of Resident #26's Comprehensive Care Plan, dated 07/06/2024, reflected the resident had oxygen therapy due to ineffective gas exchange and one of the interventions was oxygen at 2 lpm per nasal canula.</p> <p>Review of Resident 26's Physician's Order, dated 05/29/2024, reflected, OXYGEN 3-4L/MIN VIA NASAL CANNULA every shift for SOB/wheezing/LOW OXYGEN SAT LESS THAN 92% and prn.</p> <p>Observation on 07/09/2024 at 9:37 AM revealed Resident #26 was on oxygen therapy at 3 liters per minute via nasal cannula. It was observed that there was no Oxygen In Use sign outside the door of the resident.</p> <p>Observation and interview with LVN B on 07/10/2024 at 10:46 AM, LVN B said there should be a sign outside the room of the residents that use oxygen. LVN B said the sign was to remind the staff and the visitors that oxygen was being used inside the facility. She said oxygen could be a dangerous fire hazard. She said adequate precautions should be in place. LVN B said she would look for a Oxygen In Use sign. LVN B came back to the room and placed the Oxygen In Use sign outside Resident #26's room.</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 - Some</p>	<p>2. Record review of Resident #30's Face Sheet, dated 07/11/2024, revealed he was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included COPD and obstructive sleep disorder.</p> <p>Record review of Resident #30's Quarterly Minimum Data Set (MDS) dated [DATE] revealed, she had a Brief Interview for Mental Status (BIMS) score of 07 (severe cognitive impairment) and an active diagnosis of COPD.</p> <p>Record review of Resident #30's physician's orders dated 07/11/24 revealed the resident had active orders for may use oxygen @ 4 L/M (liters per minute) via nasal cannula every shift.</p> <p>An observation on 07/09/24 at 11:01 AM revealed Resident #30 not being in his room and his oxygen mask was observed sitting on a stand exposed, and not in a sealed bag.</p> <p>In an interview and observation on 07/10/24 at 01:55 AM with RN M, she stated she was the floor nurse for the North Hall and she acknowledged that Resident #30 did use an oxygen concentrator. She stated that when the resident's mask was not in use, it had to be placed in a sealed bag. She was shown a picture of Resident #30's mask sitting exposed and uncovered. She stated she had observed that today and had made sure that it was bagged. She stated the CNAs were supposed to remind the nurses if they observed masks not stored in a bag. She stated the risk of not placing the resident's mask in a sanitized bag could result in the resident having respiratory concerns.</p> <p>3. Review of Resident #189's Face Sheet, dated 07/09/2024, reflected that resident was a [AGE] year-old male admitted on [DATE]. Resident #189 had a diagnosis of obstructive sleep apnea (a sleep disorder where breathing is interrupted repeatedly during sleep).</p> <p>Review of Resident #189's Comprehensive Care Plan, dated 07/05/2024, reflected resident required the use of CPAP related to sleep apnea and one of the interventions was the resident will use device as ordered.</p> <p>Review of Resident #189's Physician's Order, dated 07/05/2024, reflected, CPAP AT HS AND AS NEEDED FOR NAP IN DAY TIME. at bedtime for SLEEP APNEA.</p> <p>Observation and interview on 07/09/2024 at 9:08 AM revealed Resident #189 was in his wheelchair inside his room. Resident #189 had a CPAP machine on his bed side table and a CPAP mask was connected to the machine. The CPAP mask was noted on top of the CPAP machine. The CPAP mask was not bagged. Resident #189 stated he used the CPAP machine at night. The resident said staff would put the CPAP on him at night and would take it off in the morning. He said he never saw a plastic bag for the CPAP mask and nobody told him to put the mask one if ever he would take it off.</p> <p>Observation and interview with LVN B on 07/09/2024 at 9:53 AM, LVN B stated the CPAP mask should not have been exposed nor touching anything because it could cause contamination and possible infection. LVN B said the CPAP mask should be bagged when not in use. LVN B said she did not notice the CPAP mask was not bagged and that there was no bag for the CPAP mask. LVN B said the resident would sometimes take the CPAP mask off but said she should have monitored if it was in a plastic bag. LVN B saw the CPAP mask on top of the CPAP machine and said she would get a plastic bag for the mask, clean the mask, and place it inside the plastic bag.</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 - Some</p>	<p>In an interview with DON on 07/11/2024 at 8:10 AM, the DON stated the CPAP mask should be bagged when not in use. He said if the CPAP mask was not bagged, exposed, or touching surfaces that were not clean, then oxygen administration could be compromised. The DON said it could also result to cross contamination and respiratory infections. He said the expectation was for the CPAP mask would be stored properly. He added the nasal cannula and the breathing mask for nebulization should also be bagged for the same reason. With regards to signage for oxygen, the DON said there should be a Oxygen In Use sign outside the door of the resident using oxygen. The sign was for safety purposes. He continued that oxygen was a flammable substance and could cause an explosion if somebody lit a cigarette near the room. He said the facility was a non-smoking facility but it would be prudent to remind the residents, staff, and visitors. He said he was responsible in putting the sign on the door of the resident and he must have overlooked it. He said the expectation was there would be an Oxygen In Use sign on every door of the residents using oxygen. The DON concluded that moving forward, he would do an in-service about bagging the CPAP mask and would continually remind them to be diligent in making sure the procedures for respiratory care were followed. He said he would also do a round to make sure all the residents using oxygen has a sign outside their door.</p> <p>In an interview with the ADON on 07/11/2024 at 8:39 AM, the ADON stated the CPAP mask should be bagged when the resident was not using it to prevent cross contamination and infection. She said the staff who take off the mask should put it in a bag. She said if the resident was the one taking it off, there should be a bag ready for them to put the mask in. She also said that the resident should be educated why the mask should be bagged. She said the expectation was for the staff to bag the CPAP mask. She said, not just the CPAP mask but also the nasal cannula and the mask used for nebulizer should also be bagged. She said it was important that there was an Oxygen In Use sign outside the door of a resident using oxygen. She said the sign was for safety precaution so everybody in the building would know oxygen was being used in the building. She said she would coordinate with the DON to do an in-service pertaining to bagging the CPAP mask, nasal cannula, and breathing mask when the residents were not using them and making sure there was a sign outside the doors of the resident in oxygen administration whether continuously or as needed.</p> <p>In an interview with the Administrator on 07/11/2024 at 8:49 AM, the Administrator stated that in general, the CPAP masks should be stored properly to prevent respiratory issues or exacerbation of whatever respiratory issues the residents already had. The Administrator said the expectation was for the staff to be mindful during their rounds and make sure the CPAP masks were bagged. The Administrator said it was important that there was sign outside the door of the residents using oxygen for safety purposes. She said oxygen was a flammable substance. The Administrator said she would check if the clinicians already did correct the issue.</p> <p>Record review of facility's policy, Oxygen Administration Nursing Policy & Procedure Manual 2003 revised February 13, 2007 revealed Oxygen therapy includes the administration of oxygen (O2) in liters/minute (l/min) by cannula or face mask to treat . O2 therapy is also prescribed to ensure oxygenation of all body organs and systems . 11. Place . signs in area when oxygen is administered.</p> <p>A policy for masks being bagged was requested on 07/10/2024 at 1:45 PM and followed-up on 07/11/2024 at 9:40 AM. The Corporate Nurse said the facility did not have a policy specific for masks being bagged.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055</p> <p>Based on observation, interviews, and record reviews the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food storage, labeling, dating, and kitchen sanitation.</p> <p>The facility failed to ensure food in the facility's refrigerator, was labeled and dated according to guidelines.</p> <p>The facility failed to ensure the ice machine and ice scoop holder were thoroughly cleaned.</p> <p>The facility failed to ensure food in the facility's freezer, was labeled and dated according to guidelines.</p> <p>The facility failed to ensure kitchen equipment was thoroughly cleaned.</p> <p>These failures could place residents at risk for cross contamination and other air-borne illnesses.</p> <p>Findings included:</p> <p>Observations on [DATE] from 09:05 AM to 09:20 AM in the facility's only kitchen reflected:</p> <p>Three large containers, containing flour, sugar, and rice had dust and dirt particles all over the top of them.</p> <p>Two miniature pizzas in a zip locked bag had a shelf life dated ,d+[DATE] and use by date of [DATE] 4 . There was no visible expiration date.</p> <p>One frozen whole ham was unlabeled and undated. There was no visible expiration date.</p> <p>One large frozen piece of meat in a zip locked bag, which was later determined to be a pork butt, was unlabeled and undated with the stored date.</p> <p>Two large bags of frozen broccoli were dated ,d+[DATE] but did not contain the year . There were no visible expiration dates.</p> <p>Two large bags of frozen onion rings were undated and there were no visible expiration dates.</p> <p>One small bag of previously opened breaded zucchini was unlabeled and undated with the stored date.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The ice machine, located in the dry storage area, had dust and dirt particles along the outside of the unit. The inside of the unit had light dirt stains along the inside panel of the unit, which also touched the ice. The upper inside of the door had rust along a metal bar that stretched horizontally along the inside door.</p> <p>The blue ice scooper holder, located near the ice machine, had a lot of white stains along the walls and the bottom of the holder.</p> <p>The milk dispenser, located in the dining area, had dust and dirt particles all over the unit. One of the milk dispensing tips had an orange colored stain along the tip.</p> <p>The drink stirrer holder, located in the dining area, had white dust and dirt particles all over the outside of the holder.</p> <p>An interview on [DATE] at 01:45 PM with the DM and Dietician, they were shown the concerns observed in the kitchen. The DM stated she had everyone assigned to storing the food and any expired foods. She stated when she got to the facility, the items were already being dated with just the month and day. The Dietician stated that she thought it was being done because their vendors would not take the items back with the year on them. The DM stated that the Director of Maintenance was responsible for cleaning the ice machine. She stated that she and her team were responsible for ensuring the containers, and kitchen equipment were cleaned, including the milk dispenser. The DM and Dietician stated they would in-service the team on the food storage requirements and would remove the concerns observed. She stated she had just been at the facility for four months and this was her first survey. They stated the risk of the concerns not being addressed could result in food contamination.</p> <p>In an interview on [DATE] at 02:00 PM with the Maintenance Director, he stated that he was responsible for ensuring the ice machine was cleaned on the inside. He stated that he cleaned the machine once a month . He was shown pictures of the rust inside the ice machine located on the inside of the door or the machine. He stated that he did not know that there was rust on it and would have it cleaned right away. He stated the risk for not cleaning the ice machine thoroughly could result in residents getting sick.</p> <p>An interview on [DATE] at 11:00 AM with the Administrator, she was made aware of the findings in the kitchen. She stated that she expected the kitchen to meet all required expectations. She stated the kitchen area had made some improvements with the new Dietary Manager and she was sure that the concerns will be addressed quickly. She stated she would follow up with the DM. She stated the risk of the concerns not being addressed could result in food contamination.</p> <p>Record Review of the facility's policy on Food Storage dated ,d+[DATE], revealed Foods shall be received and stored in a manner that complies with safe food handling practices. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date).</p> <p>Record Review of the facility's policy on Food Storage dated ,d+[DATE], revealed It is the policy of this facility that food storage areas shall be maintained in a clean, safe, and sanitary manner. 1. Food storage areas shall be clean at all times.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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 ,d+[DATE].18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts ,d+[DATE] - ,d+[DATE].</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>Based observation, interview, 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 five (Resident #23, Resident #19, Resident #9, Resident #28, Resident #1, and Resident #26) of twelve residents observed for infection control.</p> <p>1. The facility failed to ensure that CNA A changed his gloves and perform hand hygiene while providing incontinent care to Resident #23.</p> <p>2. The facility failed to ensure that LVN B sanitized the blood pressure cuff between Resident #19, Resident #9, Resident #28, and Resident #26.</p> <p>These failures could place the residents at risk of cross-contamination and development of infections.</p> <p>Findings included:</p> <p>1. Review of Resident #23's Face Sheet, dated 07/09/2024, reflected resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included hemiplegia (paralysis of one side of the body), hemiparesis (weakness on one side of the body), and weakness.</p> <p>Review of Resident #23's Comprehensive MDS Assessment, dated 05/01/2024, reflected Resident #23 had a moderate impairment in cognition with a BIMS score of 09. The Comprehensive MDS Assessment indicated Resident #23 was always incontinent for bowel and bladder.</p> <p>Review of Resident #23's Comprehensive Care Plan, dated 07/07/2024, reflected resident had potential for pressure ulcer development related to incontinence of bladder and bowel one of the interventions was to wash, rinse, and dry perineum (the space between the anus and the genitals).</p> <p>Observation and interview on 07/09/2024 at 10:42 AM, CNA A said she would check if Resident #23 needed to be changed then said she would just go ahead and change the resident. CNA A prepared the brief and wipes. CNA A washed her hands, put on the PPE, and then lowered the head of the bed. After lowering the head of the bed, CNA A pulled the trash can beside her with her gloved hands. CNA A then grabbed the new brief from the overbed table, opened it, and put it parallel to the resident's legs. CNA A did not change her gloves nor sanitize her hands after touching the waste can. CNA A unfastened the brief on both sides and pushed the front part of the brief between the legs of the resident. CNA A pulled some wipes and started to clean the front of the resident from front to back. She did it five times. CNA A rolled the resident towards the wall and cleaned the bottom of the resident. After cleaning the resident's bottom, CNA A pulled the soiled brief and threw it in the trash can. CNA A took the new brief placed it at the side of the resident, put it at the bottom of the resident, and fixed it. CNA A did not change her gloves nor sanitize before touching the new brief. CNA A rolled the resident back. CNA A cleaned the front part again and then closed the brief and fastened it to both sides. CNA A did not change her gloves all throughout the process of incontinent care. CNA A did not wash her hands after doing incontinent care.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with CNA A on 07/09/2024 at 11:11 AM, CNA A stated she was able to wash her hands before doing incontinent care but was not able to wash her hands after incontinent care. She said she forgot to do so because she went out of the room to get some linens. CNA A said it was also important to change the gloves after touching the trash can and after pulling the soiled brief to prevent cross contamination. She said cross contamination could eventually cause infection.</p> <p>2. Review of Resident 19's Face Sheet, dated 07/09/2024, reflected resident was a [AGE] year-old male admitted on [DATE]. Resident #19 was diagnosed with hypertension.</p> <p>Review of Resident #19's Quarterly MDS Assessment, dated 05/17/2024, reflected resident had moderate impairment in cognition with a BIMS score of 10. The Quarterly MDS Assessment indicated hypertension as one of Resident #19's primary medical condition.</p> <p>Review of Resident #19's Comprehensive Care Plan, dated 07/09/2024, reflected resident had hypertension and one of the interventions was give anti-hypertensive medications as ordered.</p> <p>Review of Resident #19's Physician's Order for amlodipine, dated 06/28/2024, reflected Amlodipine Besylate Tablet 10 MG. Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION HOLD IF BP <100/60 OR HR<60.</p> <p>Review of Resident #19's Physician's Order for lisinopril, dated 01/10/2023, reflected Lisinopril Tablet 10 MG. Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION HOLD IS SBP IS <110 OR HR IS <60.</p> <p>Observation on 07/10/2024 at 7:10 AM revealed LVN B was preparing Resident #19's medication. She picked up the blood pressure cuff from the medication cart and went inside the resident's room and placed the blood pressure cuff on Resident #19's arm. After the blood pressure reading was completed, LVN B placed the blood pressure cuff on top of the medication cart, prepared the medications, and gave the medications to Residents #19. She did not sanitize the blood pressure cuff.</p> <p>Review of Resident 9's Face Sheet, dated 07/10/2024, reflected resident was a [AGE] year-old male admitted on [DATE]. Resident #9 was diagnosed with hypertension.</p> <p>Review of Resident #9's Quarterly MDS Assessment, dated 04/30/2024, reflected resident had severe impairment in cognition with a BIMS score of 07. The Quarterly MDS Assessment indicated hypertension as one of Resident #9's primary medical condition.</p> <p>Review of Resident #9's Comprehensive Care Plan, dated 07/07/2024, reflected resident had hypertension and one of the interventions was give anti-hypertensive medications as ordered.</p> <p>Review of Resident #9's Physician's Order for amlodipine, dated 05/09/2023, reflected Amlodipine Besylate Tablet 10 MG. Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION HOLD IF BP <100/60 OR HR<60.</p> <p>Review of Resident #9's Physician's Order for lisinopril, dated 05/20/2024, reflected Lisinopril Oral Tablet 40 MG (Lisinopril). Give 1 tablet by mouth one time a day for hold for sbp<110, dbp<60 hr<60 related to ESSENTIAL (PRIMARY) HYPERTENSION.</p> <p>(continued on next page)</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 07/11/2024
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.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 07/10/2024 at 7:55 AM revealed LVN B was preparing Resident #9's medication. She picked up the blood pressure cuff from the medication cart and went inside the resident's room and placed the blood pressure cuff on Resident #9's arm. After the blood pressure reading was completed, LVN B placed the blood pressure cuff on top of the medication cart, prepared the medications, and gave the medications to Residents #9. She did not sanitize the blood pressure cuff.</p> <p>Review of Resident #28's Face Sheet, dated 07/10/2024, reflected resident was a [AGE] year-old male admitted on [DATE]. Resident #28 had a diagnosis of hypertension.</p> <p>Review of Resident #28's Quarterly MDS Assessment, dated 05/10/2024, reflected resident was cognitively intact with a BIMS score of 13. The Quarterly MDS Assessment indicated hypertension as one of Resident #28's primary medical condition.</p> <p>Review of Resident #28's Comprehensive Care Plan, dated 07/07/2024, reflected resident had hypertension and one of the interventions was give anti-hypertensive medications as ordered.</p> <p>Review of Resident #28's Physician's Order for amlodipine, dated 05/04/2023, reflected Amlodipine Besylate Tablet 10 MG. Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (110) HOLD IF BP <100/60 OR HR<60.</p> <p>Review of Resident #28's Physician's Order for lisinopril, dated 05/17/2023, reflected Lisinopril Oral Tablet 40 MG (Lisinopril). Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (110) HOLD IF BP IS <100/60 OR HR <60.</p> <p>Observation on 07/10/2024 at 8:12 AM revealed LVN B was preparing Resident #28's medication. She picked up the blood pressure cuff from the medication cart and went inside the resident's room and placed the blood pressure cuff on Resident #28's arm. After the blood pressure reading was completed, LVN B placed the blood pressure cuff on top of the medication cart, prepared the medications, and gave the medications to Residents #28. She did not sanitize the blood pressure cuff.</p> <p>Review of Resident #26's Face Sheet, dated 07/09/2024, reflected resident was a [AGE] year-old male admitted on [DATE]. Resident #26 had a diagnosis of hypertension.</p> <p>Review of Resident #26's Quarterly MDS Assessment, dated 05/10/2024, reflected resident had moderate impairment in cognition with a BIMS score of 08. The Quarterly MDS Assessment indicated hypertension as one of Resident #26's primary medical condition.</p> <p>Review of Resident #26's Comprehensive Care Plan, dated 07/06/2024, reflected resident had hypertension and one of the interventions was give anti-hypertensive medications as ordered.</p> <p>Review of Resident #26's Physician's Order for amlodipine, dated 05/04/2023, reflected Amlodipine Besylate Tablet 10 MG. Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (110) HOLD IF BP <100/60 OR HR<60.</p> <p>Review of Resident #26's Physician's Order for lisinopril, dated 03/29/2024, reflected Lisinopril Oral Tablet 20 MG (Lisinopril). Give 1 tablet by mouth one time a day for hold for sbp<110, dbp<60 hr<60 related to ESSENTIAL (PRIMARY) HYPERTENSION (110).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 07/10/2024 at 8:12 AM revealed LVN B was preparing Resident #26's medication. She picked up the blood pressure cuff from the medication cart and went inside the resident's room and placed the blood pressure cuff on Resident #26's arm. After the blood pressure reading was completed, LVN B placed the blood pressure cuff on top of the medication cart and then prepared and gave the medications to Residents #26. She did not sanitize the blood pressure cuff.</p> <p>In an interview with LVN B on 07/10/2024 at 9:48 AM, LVN B stated she obtained the blood pressure of the residents before giving the medication for hypertension to know if the medication needed to be held or not. LVN B said the proper thing to do was to wash or sanitize her hands before and after giving medications. LVN B said the blood pressure cuff should be sanitized as well after using it and before using it on another resident. LVN B then acknowledged she forgot to sanitize the blood pressure cuff in between residents when she passed the medications. LVN B stated not sanitizing the blood pressure cuff in between residents could cause infection to transfer from one resident to another. LVN B added if a resident already had an infection, that infection could be transferred to another resident because the reusable item was not sanitized.</p> <p>In an interview with DON on 07/11/2024 at 8:10 AM, the DON stated that the blood pressure cuff should be sanitized every after use. He said that not sanitizing the blood pressure cuff could cause cross contamination or development of new infections. The DON added that was also true for the glucometer and the pulse oximeter. The DON stated he was made aware by the CNA involved about the infection control issue during incontinent care. The DON said he just did a check-off about incontinent care. He said he showed the staff how to do incontinent care and then let the staff returned the demonstration. He said he used a mannequin during his demonstration. He said the CNA involved was present during the time of the check-off so he did not know what happened. The DON said every staff should wash their hands before and after every care. He said gloves should be changed and the hands should be sanitized after cleaning the resident's buttocks. He said the gloves should have been changed when the trash can was touched. He said not washing the hands, not changing the gloves, and not sanitizing the hands in between changing of gloves could result to cross contamination and infection. The DON said the expectation was for the staff to wash their hands before and after every care, change their gloves when transitioning from a dirty area to a clean area, sanitizing their hands when changing their gloves, and sanitizing the blood pressure cuff after every use. The DON said he would do a one-on-one in-service with CNA A about washing of hands and changing of gloves and then talk to LVN B about sanitizing the blood pressure cuff. He added he would do an in-service about infection control for all the staff. He concluded that he would continually remind the staff to be attentive to the procedures for infection control and that he would personally monitor infection control.</p> <p>In an interview with the ADON on 07/11/2024 at 8:39 AM, the ADON stated the blood pressures were checked first before administering medications for hypertensions. The ADON said since the nurses were only using one blood pressure cuff for all the residents, the blood pressure cuff should be sanitized every after use to prevent cross contamination. The ADON said, during incontinent care, the staff must always change their gloves and sanitize the hands before touching the new brief. She said the expectation was for the blood pressure cuff to be sanitized in between residents and staff would wash their hands, and change their gloves to prevent infection among the residents. She said she would coordinate with the DON on how to go forward.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with the Administrator on 07/11/2024 at 8:49 AM, the Administrator stated not washing the hands nor sanitizing them could contribute to cross contamination. She said not sanitizing the blood pressure cuff would do the same. The Administrator said the expectation was for the staff to make sure all items and equipment used by the residents were sanitized and the gloves were changed during incontinent care for the basic reason of infection control. She said she would collaborate with the clinicians to in-service the staff about infection control.</p> <p>Review of facility policy, Perineal Care Female (With or without catheter) Nursing Policy and Procedure Manual 2003 rev. December 8.2009 revealed Purpose: To clean the female perineum without contaminating the urethral area with germs from the rectal area . Procedural Guidelines . A. Beginning Steps . a. Wash hands . H. Wash hands and put on clean gloves for perineal care . I. Gently wash . d. Change gloves . g. pat dry . h. Change gloves . J. Cleaning the rectal and buttocks area . c. Change gloves . K. Closing steps . a. if gloved, remove and discard gloves. Wash hands.</p> <p>Record review of facility's policy Infection Control Plan: Overview updated 03/2023 revealed The facility will establish and maintain an Infection Control Program designed . to help prevent the development and transmission of disease and infection . Environmental Infection Control . All non-dedicated, non-disposable medical equipment used for the patient should be cleaned and disinfected . before use on another patient.</p>		