STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675995	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Rehabilitation Center	2244 Brinker Rd Denton, TX 76208

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675995	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Rehabilitation Center	2244 Brinker Rd Denton, TX 76208

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to implement services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for ten (Resident # 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) reviewed for care plans Based on observation, record review and interview the facility failed to implement services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for ten (Resident # 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) reviewed for care plans The facility failed to ensure Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, and 10 were properly supervised while smoking in the smoking area of the facility. The facility failed to implement adequate supervision for Resident #1, #2, #3, #4,# 5, #6, #7, #8, #9, and #10 while smoking in the smoking area of the facility. 1. Record review of Resident #1's Face Sheet, dated 09/11/25, reflected she was an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included Alzheimer's Disease (cognitive decline) and COPD.Record review of Resident #1's Quarterly MDS assessment, dated 8/07/25, reflected she had a BIMS score of 7 (severe cognitive impairment). For active diagnosis it reflected COPD. For ADL care it reflected the resident required supervision.Record review of Resident #1's Comprehensive Care Plan, dated 7/17/5, did not reflect a care plan for smoking.Record review of Resident #1's Smoking assessment, dated 9/09/25, reflected the resident required supervision while smoking.2. Record review of Resident #2's Face Sheet, dated 09/11/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included respiratory failure and need for assistance with personal care. Record review of Resident #2's Quarterly MDS assessment, dated 9/04/25, reflected she had a BIMS score of 3 (severe cognitive impairment). For active diagnosis it reflected respiratory failure. For ADL care it reflected the resident required supervision.Record review of Resident #2's Comprehensive Care Plan, dated 8/09/25, reflected the resident was a smoker and an intervention was for the resident to be supervised while smoking for safety.Record review of Resident #2's Smoking assessment, dated 9/03/25, reflected the resident required supervision while smoking.3. Record review of Resident #3's Face Sheet, dated 09/11/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included respiratory failure and COPD (lung disease).Record review of Resident #3's Quarterly MDS assessment, dated 9/07/25, reflected she had a BIMS score of 13 (intact cognitive response). For active diagnosis it reflected acute respiratory failure. Record review of Resident #3's Comprehensive Care Plan, dated 8/09/25, reflected the resident was a smoker and an intervention was for the resident to be supervised while smoking for safety.Record review of Resident #3's Smoking assessment, dated 8/07/25, reflected the resident required supervision while smoking. 4. Record review of Resident #4's Face Sheet, dated 09/11/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included respiratory failure and COPD (lung disease).Record review of Resident #4's Quarterly MDS assessment, dated 8/29/25, reflected she had a BIMS score of 7 (severe cognitive impairment). For active diagnosis it reflected acute respiratory failure. Record review of Resident #4's Comprehensive Care Plan, dated 7/17/25, did not reflect a care plan for smoking.Record review of Resident #4's Smoking assessment, dated 8/07/25, reflected the resident required supervision while smoking. 5. Record review of Resident #5's Face Sheet, dated 09/11/25, reflected she was a [AGE] year-old female admitted to the facility on 2/06//24. Relevant diagnoses included Parkinson's disease (nerve damage) and COPD (lung disease).Record review of Resident #5's Quarterly MDS assessment, dated 8/08/25, reflected she had a BIMS score of 12 (moderate cognitive impairment). For active diagnosis it reflected Parkinson's disease and congestive heart failure. Record review of Resident #5's Comprehensive Care Plan, dated 9/03/25, reflected the resident was a smoker and an intervention was for the resident to be supervised while smoking for safety.Record review of Resident #5's Smoking assessment, dated 8/26/25, reflected the resident required supervision while smoking. 6. Record review of Resident #6's Face Sheet, dated 09/11/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included Multiple Sclerosis (nerve damage) and lack of coordination.Record review of Resident #6's Quarterly MDS assessment, dated 8/28/25, reflected she had a BIMS score of 13 (intact cognitive response). For active diagnosis it reflected Multiple Sclerosis and lack of coordination. Record review of Resident #6's Comprehensive Care Plan, dated 08/25/25, reflected the resident was a smoker and an intervention was for the resident to be supervised while smoking for safety.Record review of Resident #6's Smoking assessment, dated 9/09/25, reflected the resident required supervision while smoking.7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675995	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Rehabilitation Center	2244 Brinker Rd Denton, TX 76208

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that each resident received adequate supervision and assistance to prevent accidents for one of thirteen residents (Resident #12) reviewed for accidents and hazards.The facility failed to ensure Resident #12 received the appropriate supervision to prevent elopement from the facility on 6/23/2025 and 07/13/2025.The non-compliance was identified as PNC on 09/11/25 and the IJ template was provided the facility on 09/11/25 at 3:10 PM. The noncompliance began on 07/13/2025 and ended 07/13/2025. The facility corrected the non-compliance before the survey began.These failures could place the residents at risk of serious harm, injury and death from wandering outside the facility in unfamiliar surroundings. . Findings include: Record review of Resident #12's Face Sheet, dated 09/11/2025, reflected the resident was an [AGE] year-old male who admitted to the facility on [DATE]. Resident #12 had diagnoses which included moderate dementia with agitation, diabetes, and unsteadiness on his feet. Resident #12 was ambulatory with a walker. Record review of Resident #12's Quarterly MDS (tool used to assess health status) Assessment, dated 07/02/2025, reflected moderately impaired cognition with a BIMS (screening tool to assess cognitive status) score of 09. Section I (Active Diagnoses) reflected Resident #1's diagnoses included hypertension (high blood pressure), dementia (decline in cognitive function that interferes with daily life), and diabetes (the body does not use insulin effectively). Section N (Medications) indicated Resident #12 received a daily insulin (medication to treat elevated blood glucose) injection. Record review of Resident #'12's Comprehensive Care Plan, dated 05/14/25 and updated 06/23/2025, reflected the resident had impaired cognitive function or impaired thought process related to dementia. One intervention, initiated 06/23/2025, was for visual checks every 15 minutes for a 24-hour period until the resident was no longer at risk for elopement. Additional review of Resident #12's Comprehensive Care Plan, dated 05/14/2025 and updated 06/23/2025, reflected Resident #1 was at risk for elopement as evidenced by attempted elopement. Interventions included Psych services to evaluate and treat. Date initiated 06/23/2025… Determine the reason the resident is attempting to elope… Intervene as appropriate. Date initiated 06/24/2025. Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. Date initiated: 06/24/2025. Distract resident from elopement attempts by offering pleasant diversions, structured activities, food, conversation, television, books. Date initiated: 06/24/2025. If the resident is exit seeking, stay with the resident, and notify the charge nurse by calling out, sending another staff member, call system. Date initiated: 06/24/2025.” (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675995	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Rehabilitation Center	2244 Brinker Rd Denton, TX 76208

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #12's Progress Notes, dated 06/23/2025, reflected at about 7:00 PM Resident #12 pushed his way past visitors who were exiting the front door. Staff followed Resident #12 to the parking lot where he was agitated and refused to return to the building. Resident #12's family member was called, and after speaking with the resident, Resident #12 agreed to go back inside the facility. Resident #12 told staff members his family was out of town and there was no one to take care of the farm. Record review of Resident #12's Psychiatry Progress Note, dated 07/09/2025, reflected “Medical Necessity: Nursing staff request to address a documented psychiatric issue of concern that requires a timely evaluation and medical intervention. Patient instability or change in condition requiring timely mental status examination to establish appropriate treatment intervention and/or change in treatment intervention…Continue current medication… Monitor patient's behavioral signs and symptoms on each subsequent encounter to determine effectiveness of the medications.” Record review of CNA J's witness statement, dated 07/13/2025, reflected that she answered the facility's phone on 07/13/2025 at about 2:30 PM. A family member reported not seeing Resident #12 on the camera in his room. CNA J checked the resident's room and reported to his nurse a family had called, and the resident was not in his room. An attempt to interview CNA J on 09/11/2025 was unsuccessful. CNA J no longer worked at the facility. Record review of RN I's witness statement, dated 07/13/2025, reflected “This RN visualized resident between 1330 (1:30 PM) and 1400 (2:00 PM) with tray of food on tray table and resident in recliner.” RN I indicated she was called to speak with the family of another resident and then assisted with resident care. “This RN came out of room and weekend manager notified resident was not located. This RN organized staff, building was searched systematically; this RN looked at out on pass log and resident was not signed out. Outside perimeter was checked by this RN and a CNA walking in opposite directions. This RN notified weekend manager unable to locate resident and was going to call 911. This RN called responsible party who stated resident was not out on pass, and was sending family member to facility. This RN called 911. Police dispatched. Provided photo, face sheet description. DON and police assumed search. DON notified this RN resident was found by police, went to hospital, and would discharge to secure unit. This RN notified physician.” An attempt to interview RN I on 09/11/2025 and 09/13/2025 was unsuccessful. Record review of Resident #12's Comprehensive Care Plan, dated 05/14/2025 and updated 07/13/2025, reflected Resident #12 was at risk for wandering. Interventions included “Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television. Date initiated 07/13/2025. If the resident is exit seeking, stay with the resident, and notify the charge nurse by calling out, sending another staff member, call system, etc. Date initiated 07/13/2025. Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. Date initiated 07/13/2025. Date initiated 07/13/2025. Referral to secure care unit. Date initiated: 07/13/2025. ” (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675995	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Rehabilitation Center	2244 Brinker Rd Denton, TX 76208

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #12's hospital record, dated 07/13/2025, reflected he was admitted to the intensive care unit and treated for severe hyperthermia (critical condition characterized by elevated body temperature) and acute hypoxic respiratory failure (body does not have enough oxygen in the blood) that required intubation (insertion of a tube into the airway to assist with breathing). The environmental temperature on 07/13/2025 was 93 degrees. During an interview on 09/11/2025 at 9:35 AM, the Social Worker stated Resident #12 eloped on 07/13/2025 and police were able to find him not far from the facility by the train railway. She stated the resident was taken to the hospital. She stated Resident #12's family had recently taken a trip and explained to the resident they would not be visiting. She stated Resident #12 was concerned about the farm and who was going to take care of it. She stated the resident had been distraught about it and she believed he had started trying to figure out how to get back to the farm. She stated Resident #12 was discharged from the hospital to a facility with a secure unit. She stated he had not eloped before. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675995	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Rehabilitation Center	2244 Brinker Rd Denton, TX 76208

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/11/2025 at 9:55 AM, the DON stated Resident #12 rarely left his room except to get coffee. He stated the resident sat in the recliner in his room. The DON stated about two weeks prior to the elopement on 07/13/2025, Resident #12 went out the front door of the facility with visitors. He stated staff immediately followed after him and the resident refused to come back into the facility. He stated he called the resident's family member who reported telling the resident his family was going out of town and would not be coming to the facility to see him. The family member stated the resident asked who was taking care of the farm and he was reminded he had sold it years prior. The DON stated the family member spoke with the resident on the phone and coaxed him to go back inside the building. The DON stated he felt like it was an isolated incident and the family member stated the resident would not be told in the future when family members were going out of town. The DON stated the resident was placed on 1:1 monitoring for 24 hours and evaluated to ensure the resident was not displaying exit seeking behavior. He stated the physician ordered labs and a urinalysis. He stated the facility changed the door code, referred the resident to psych services, and updated his care plan. The DON stated about two weeks later, on 07/13/2025 at about 2:30 PM, a family member called the facility and asked for staff to check the Resident #12's restroom to see if he needed help because they did not see Resident #12 on the camera in his room. The DON stated the resident could not be located inside or outside the building and the police were called. He stated the resident was located a couple of hours from the time the resident was noticed missing. He stated the resident was located not far from the facility by the train tracks. The DON stated he went to the emergency room to check on the resident and was told the resident was intubated and being treated for hyperthermia (elevated body temperature). He stated the resident was extubated the following day. The DON stated he notified family the resident would not be able to return because the facility did not have a locked unit for males. He stated Resident #12 discharged from the hospital to another facility with a memory care unit. The DON stated all residents had a risk assessment for elopement on admission, quarterly, and as needed. He stated after the elopement on 07/13/2025, a risk assessment was completed for all residents in the building and staff received in-service training on monitoring for exit-seeking behaviors and what to do if alerted of an elopement. The DON stated no residents in the facility had a wander guard. He stated no other residents' assessment indicated a high risk for elopement. He stated the only residents who triggered high risk for elopement were located in the memory care unit. The DON stated staff had also participated in weekly elopement drills since the incident. He stated all exit doors were inspected daily to ensure each door functioned properly, the door access codes were changed, and signs were posted at all exits in English and Spanish notifying visitors to ensure residents did not exit and were given the door code. He stated any female resident identified with exit seeking behavior or was at risk for elopement was transferred to the memory care unit and males displaying exit seeking behavior were transferred to a facility with a memory unit for male residents. The DON stated during the day, when the receptionist was at the front desk, the front door was unlocked. He stated when she went to break or left at the end of the day, the front door was locked and to enter or exit required entering a code on the keypad. He stated the facility had also employed a receptionist on weekends to monitor the front door. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675995	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Rehabilitation Center	2244 Brinker Rd Denton, TX 76208

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/11/2025 at 10:20 AM, the Administrator stated she was not at the facility at the time of the elopement but the facility provided in-service training and had weekly elopement drills with staff members. She provided a binder with documents, dated 07/13/2025, of in-service training on resident rights, abuse, neglect, and exploitation, and elopement prevention and response. She provided documentation of weekly elopement drills and a log of daily inspections of all exit doors completed since the elopement on 07/13/2025. The Administrator also provided documentation showing all residents were assessed for risk elopement on 07/13/2025. She stated prevention was key and the risk was the safety of the residents. She stated it was important for staff to know policies and procedures and to react appropriately. She stated it was important for staff to be alert for any exit seeking communication or behaviors and notify the nurse, DON, or leadership to assess the resident. During an interview on 09/11/2025 at 12:18 PM, Resident #12's family member stated they called the facility at about 2:30 PM on 07/13/2025, after not observing the resident on the camera in his room for 30 – 45 minutes. The family member stated that after the resident was not located in or around the building, the police were called. The family member stated the police used a drone and located Resident #12 near the train tracks, about one-third to one-half of a mile from the facility and was taken to the hospital where he was treated for a heat stroke. The family member stated he remained in the hospital for about a week before discharging to a nursing facility with a memory care unit. During a follow up interview on 09/11/2025 at 12:40 PM, the DON stated the facility had ongoing elopement drills on different shifts. He stated he hid a mannequin in different locations, including various locations outside the facility. He stated residents had participated as well. The DON stated the staff were provided with a scenario and a printed census of the residents. He stated nurses delegated to CNAs during the code orange (code used for an elopement). He stated on weekends, the weekend manager or unit manager shift took charge of delegating. He stated if the resident was not found within 30 minutes, the police were notified. He stated by that time the DON and Administrator would have already been notified. The DON stated that after all efforts to locate the residents inside the facility were exhausted, including rooms, shower rooms, restrooms, offices, and all other assigned areas, assigned staff would begin to search the perimeter. The DON stated the residents' safety was first. He stated if anyone tried to exit, staff knew to move quickly to the alarming door. He stated the front door alarm was the loudest and could be heard throughout the building. He stated the train was near the facility and the highway was less than a mile away. He stated it was important to prevent resident harm at all costs. He stated staff were in-serviced to be alert and observe residents for any exit seeking communication or behaviors. He stated all staff were required to have dementia care training and what to recognize in residents. He stated leadership had also made the decision to secure the front door at all times, even when a receptionist was on duty. He stated it required a code to be entered on the keypad for anyone to enter or exit the front door. Observation of all exit doors on 09/11/2025 at 1:35 PM revealed the doors closed and locked properly and alarms could be heard at the nurses' stations. Observation of all exit doors on 09/11/2025 at 3:05 PM revealed signs posted in English and Spanish notifying visitors to not allow residents to exit the facility and to not share the door code with the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675995	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Rehabilitation Center	2244 Brinker Rd Denton, TX 76208

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews on 09/11/2025 between 3:30 PM and 4:41 PM were conducted with multiple staff members which included the Administrator, DON, Social Worker A, Maintenance Supervisor B, Treatment Nurse C, Occupational Therapist D, Therapy Director E, Physical Therapist F, Dietary Manager G, COTA H, RN K, LVN N, CNA O, PTA P, Therapy Q, CNA R, Dietary Aide S, Floor Technician T, Student Aide U, CNA V, and LVN X. Interviews revealed staff members received elopement in-service training and participated in elopement drills. Staff were reminded to be alert to signs of exit seeking and to notify the charge nurse or DON to assess the resident as needed. Staff members were educated on their role when a code orange (elopement) was called in the facility. Census sheets were provided to cross reference and ensure each resident was present. The elopement drills included the designation of staff members to an assigned search area which included searching every room in the facility to ensure the resident was in the building and safe. If a resident was not located inside or outside the building, police, family, and the physician must be notified. No lack of knowledge or procedure was identified. The facility initiated the following interventions prior to the state surveyor entry on 09/11/2025: The facility door codes was changed and signs were placed at each exit door notifying all to not allow residents to exit the building.Record review of Resident #12's clinical file on 09/11/2025 at 11:15 AM reflected the following:-Resident #12's risk assessments on 06/23/2025 reflected the resident was not a high risk for elopement. The risk assessment completed on 07/13/2025 reflected the resident was at high risk for elopement. -Resident #12's Comprehensive Care Plan was updated with interventions on 06/23/2025 and 07/13/2025 after the resident exited the building.-Elopement risk assessments and care plans were updated on all residents in the building on 07/13/2025. -The medical doctor, psychiatrist, director of nurse, administrator, and Resident #12's family member was notified of the elopement on 06/23/2025 and 07/13/2025.-Documentation of education of staff on resident rights, abuse, neglect, and exploitation on 07/13/2025.-Documentation of education of staff on elopement prevention and response, exit seeking, and door protocols on 07/13/2025.-Documentation of elopement drills beginning 07/13/2025 and conducted weekly following the elopement. -Log of daily inspection of all exit doors beginning on 07/13/2025.- No additional elopements occurred and Resident #12 no longer resided at the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675995	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Rehabilitation Center	2244 Brinker Rd Denton, TX 76208

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 one of three residents (Resident #11) reviewed for respiratory care. The facility failed to ensure Resident 11's oxygen mask was properly stored in a bag when not in use on 09/11/25. This failure could place the residents at risk for respiratory infection and not having their respiratory needs met.Findings include: Record review of Resident #11's Face Sheet, dated 09/11/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included Acute Respiratory Failure (lack of oxygen) and Chronic Obstructive Pulmonary Disease (lung disease). Record review of Resident #11's Quarterly MDS assessment, dated 9/02/25, reflected he had a BIMS score of 12 (moderate cognitive impairment). For ADL care, it reflected the resident required total assistance and it reflected an active diagnosis of cardiorespiratory conditions. Record review of Resident #11's Comprehensive Care Plan, dated 3/16/2025, reflected the resident had COPD and one of the interventions was to provide oxygen therapy to the resident as needed. Record Review of Resident #11's Physician Orders, dated 9/11/25, reflected Ipratropium-Albuterol Inhalation Solution 0.5-2.5 MG/3ML inhale orallyevery 12 hours as needed for Bronchi muscle spasm resulting from COPD An observation on 09/11/25 at 12:43 PM, revealed Resident #11's oxygen mask unbagged, sitting on the top of a three-drawer chest. In an interview and observation on 09/11/25 at 12:45 PM, RN M stated Resident #11 used his oxygen device on an as needed basis. She stated she did not know when the last time he had used the device. She stated when the breathing device was not in use, the breathing mask should be stored in a plastic bag to avoid an infection. She stated she would discard the mask and get the resident a new one. In an interview on 09/11/25 at 12:59 PM with ADON L, she stated Resident #11 did have a device for breathing treatments on an as needed basis. She was advised of Resident #11 not having his mask bagged and she stated that the mask should be removed or bagged when not in use to avoid an infection. In an interview on 09/11/25 at 4:12 PM, the DON stated he had been at the facility for seven months. He was advised of Resident #11 being observed with an oxygen mask, unbagged while not in use. He stated he expected staff to remove the mask and then replace with a new one if needed or the mask should be bagged to avoid the resident getting an infection. Review of the facility's policy Oxygen Administration, undated, reflected Oxygen therapy includes the administration of oxygen (O2) in liters/minute by cannula or face mask to treat hypoxic conditions caused by pulmonary or cardiac diseases. The resident will maintain oxygenation with safe and effective delivery of prescribed oxygen. The resident will be free from infection.