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	12/11/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free of significant medication errors for one (Resident #1) of 5 residents reviewed for pharmacy services. The facility failed to ensure Resident #1 received the correct dosage of levetiracetam (Keppra, and anti-epileptic drug/seizure medication) from 10/09/2025 to 11/26/2025. This failure could place residents at risk of medical complications not receiving the therapeutic effects of their medications.Findings included:Record review of a facility face sheet dated 12/10/2025 for Resident #1 reflected that she was a [AGE] year-old female who initially admitted to the facility on 08.08/2025 with diagnoses that included: TRAUMATIC SUBARACHNOID HEMORRHAGE WITHOUT LOSS OF CONSCIOUSNESS, SUBSEQUENT ENCOUNTER (bleeding in the brain), UNSTEADINESS ON FEET, and UNSPECIFIED CONVULSIONS (seizures).Record review of the Quarterly MDS assessment dated [DATE] for Resident #1 reflected that the resident had a BIMS score of 99 which means that the resident was unable to complete the interview due to nonsensical responses. Resident #1 had a primary medical condition of Non-Traumatic Brain Dysfunction (stroke, internal bleeding in the brain), and the medication section indicated that Resident #1 took an anti-epileptic drug.Record review of a comprehensive care plan dated 09/19/2025 for Resident #1 reflected that the resident is at risk for wandering, at risk for falls and elopement. Record review of a hospital record dated 10/9/2025 for Resident #1 reflected that the hospital physician had ordered an increase of the amount of anti-seizure medication and Resident #1 received from levetiracetam (Keppra), by mouth, 500 milligrams twice a day to, levetiracetam, by mouth, 750 milligrams twice a day. Record review of the facility orders[BR3] dated 10/09/2025 to 11/25/2025 from the Facility Physician found that there were no changes to Resident #1's levetiracetam (Keppra), by mouth, 500 milligrams twice a day, until 11/26/2025 when the order was changed to levetiracetam (Keppra), by mouth, 750 milligrams twice a day.Record review of the Medication Administration Record for Resident #1 dated 10/01/2025 to 10/31/2025 reflected that Resident #1 received levetiracetam (Keppra), by mouth, 500 milligrams twice a day for the entire month.Record review of Medication Administration Record for Resident #1 dated 11/01/2025 to 11/30/2025 reflected that Resident #1 received levetiracetam (Keppra), by mouth, 500 milligrams twice a day until 11/26/2025 after which she started to receive levetiracetam (Keppra), by mouth, 750 milligrams twice a day.Record review of a laboratory result dated 10/11/2025 revealed that Resident #1 had a safe therapeutic level of levetiracetam (Keppra) in her system of 17.83, within the reference parameters (safe levels) of 6.00 to 40.6.Record review of a laboratory result dated 11/12/2025 revealed Resident #1 had a safe therapeutic level of levetiracetam (Keppra) in her system of 12.94, within the reference parameters (safe levels) of 6.00 to 40.6. Record review of a laboratory result dated 11/24/2025 (drawn at hospital) revealed Resident #1 had a safe therapeutic level of levetiracetam (Keppra) in her system of 20.03, within the reference parameters (safe levels) of 6.00 to 40. 6.In an observation and interview on 12/10/2025 at 12:30 PM Resident #1 was observed being assisted with eating lunch by RN A who was seated beside her. Resident #1 was unable to answer any questions, and RN A commented that Resident #1 was non-verbal. RN A further revealed that she had been the nurse on duty when Resident #1 fell on [DATE]. RN A stated that Resident #1 was a constant wanderer and that she worked on her charting in the hallway to be able to observe Resident # 1 more often. She stated that Resident #1 had passed her position in the hallway and was behind her less than a minute before she heard Resident #1 fall approximately 10 ft behind her. She stated that she immediately went to Resident #1 who was on the ground and noted that she was convulsing on the ground. She stated that she had not been able to tell if the resident fell because of a seizure, or if the seizure happened because of the fall. She stated that if Resident #1 didn't receive the ordered amount of levetiracetam (Keppra), it could expose her to a higher risk of suffering a seizure.In an interview on 12/10/2025 at 12:56 the Facility Physician revealed that he could not confirm if Resident #1 had a seizure on 10/05/2025 or on 11/24/2025. He stated that he was aware that the hospital had ordered an increase on 10/09/2025 of levetiracetam (Keppra), by mouth, 500 milligrams twice a day to, levetiracetam, by mouth, 750 milligrams twice a day. He stated that the nursing staff had missed inputting that order into the electronic health record system. He stated that if Resident #1 didn't receive the ordered amount of levetiracetam (Keppra), it could expose her to a higher risk of suffering a seizure.In an interview on 12/11/2025 at 2:20 PM the DON revealed that the facility had enacted new systems and a new check list to ensure that all orders were entered into their system. She stated that all