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	04/23/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident for one (Incident #1079379) of four incidents reviewed for reporting of alleged violations. The Administrator failed to report the results of an investigation within five working days to the State Survey Agency. This failure could place residents at risk of not receiving timely and appropriate responses to alleged violations of abuse, neglect, and/or exploitation.Findings included: Record review completed on 04/23/26 at 9:00AM of the TULIP (Texas Unified Licensure Information Portal) system revealed that no Provider Investigation Report (Form 3613-A) had been filed for Incident #1079379 (no named/identified residents). The facility had filed the Facility Reported Incident and CII Self-Report Template (the initial reports) with the State Survey Agency on 03/27/26. Record review of the Provider Investigation Report (Form 3613-A) for Incident #1079379, which occurred on 03/27/26, reflected it was completed on 04/02/26. Review of the Provider Investigation Report reflected that a thorough investigation of the alleged incident (regarding an allegation of neglect to unknown residents due to staff members wearing earbuds and being on their cell phones) was completed. During an interview with the Administrator on 04/23/26 at 12:20PM, she stated she completed the Provider Investigation Report (Form 3613-A) for Incident #1079379 but forgot to submit it to the State Survey Agency within the required 5-day timeframe upon completion. The Administrator stated the risk of not submitting the Provider Investigation Report (Form 3613-A) included a lack of timeliness in information being submitted. During an interview with the Administrator on 04/23/26 at 12:49PM, she stated the facility did not have a policy related to submitting Provider Investigation Reports (Form 3613-A) within five working days of the incident.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident's rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for two (Resident #1 and Resident #2) of seven residents reviewed for comprehensive care plans. 1.) The facility failed to ensure that Resident #1's comprehensive care plan identified nebulizer treatments as an intervention for respiratory care. 2.) The facility failed to ensure that Resident #2's comprehensive care plan identified oxygen therapy as an intervention for respiratory care. This failure could place residents at risk of not receiving proper care and services due to inaccurate care plans.Findings included: 1.) Record review of Resident #1's Face Sheet, dated 04/23/26, reflected he was an [AGE] year-old male, who was originally admitted to the facility on [DATE], with diagnoses including acute and chronic respiratory failure with hypoxia (a sudden, life-threatening inability to maintain oxygen levels, while chronic respiratory failure develops gradually, causing persistent low oxygen in the blood), idiopathic pulmonary fibrosis (a serious lung disease characterized by progressive scarring of lung tissue, making it increasingly difficult to breathe), and acute pulmonary edema (a sudden buildup of fluid in the lungs). Record review of Resident #1's MDS Assessment, dated 04/09/26, reflected he received respiratory treatments both on admission and while a resident at the facility. Record review of Resident #1's Physician's Orders, dated 04/23/26, reflected an active PRN order for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 1 vial; inhale orally every 4 hours as needed for wheezing/shortness of breath [via nebulizer]. The start date for this order was 04/03/26. Record review of Resident #1's Care Plan, dated 03/30/26 (but active as of 04/23/26), reflected no evidence that Resident #1's order for treatment via nebulizer was included in the plan of care. The only areas pertaining to respiratory status/care were that Resident #1 had pneumonia and was receiving oxygen therapy. 2.) Record review of Resident #2's Face Sheet, dated 04/23/26, reflected she was a [AGE] year-old female, who was originally admitted to the facility on [DATE], with diagnoses including acute respiratory failure with hypoxia (a potentially life-threatening condition characterized by insufficient oxygen in the blood) and chronic obstructive pulmonary disease (progressive lung disease that makes it difficult to breathe). Record review of Resident #2's MDS Assessment, dated 04/05/26, reflected she received respiratory treatments both on admission and while a resident at the facility. Record review of Resident #2's Physician's Orders, dated 04/23/26, reflected an active PRN order for continuous oxygen at 2-4 L/Min via nasal cannula to maintain her oxygen stats > 92%. The start date for this order was 04/18/26. Record review of Resident #2's Care Plan, dated 02/25/26 (but active as of 04/23/26), reflected no evidence that Resident #2's order for continuous oxygen was included in the plan of care. The only area pertaining to respiratory status/care was that Resident #2 had Emphysema/COPD. During an interview with the Director of Nursing on 04/23/26 at 10:46AM, he stated the facility had experienced staff turnover and was attempting to catch up on creating and maintaining accurate, comprehensive care plans. The Director of Nursing stated nebulizer treatments and oxygen therapy should be included in care plans. During an interview with the MDS Coordinator on 04/23/26 at 11:28AM, she stated she was responsible for completing comprehensive care plans. She said the facility's electronic charting system was having technological issues, and certain care areas were not reflected in certain care plans as of this morning. She stated she had notified IT of this issue and had initiated a new care plan for Resident #1 with all appropriate care areas triggered. The MDS Coordinator stated the risk of incomplete/inaccurate comprehensive care plans included the potential for reduced efficiency in resident care. Review of the facility's Comprehensive Care Planning policy, undated, reflected, .The (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. and .Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.

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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 establish and maintain respiratory care including oxygen services, including the safe handling, humidification, cleaning, storage, and dispensing of oxygen for two (Resident #1 and Resident #2) of seven residents reviewed for respiratory care. 1.) The facility failed to ensure that Resident #1's nebulizer mask and mouthpiece were bagged in a plastic bag. 2.) The facility failed to ensure that Resident #2's oxygen tubing/nasal cannula were bagged in a plastic bag. These failures could place residents receiving respiratory therapy at risk of health-associated infections.Findings included: 1.) Record review of Resident #1's Face Sheet, dated 04/23/26, reflected he was an [AGE] year-old male, who was originally admitted to the facility on [DATE], with diagnoses including acute and chronic respiratory failure with hypoxia (a sudden, life-threatening inability to maintain oxygen levels, while chronic respiratory failure develops gradually, causing persistent low oxygen in the blood), idiopathic pulmonary fibrosis (a serious lung disease characterized by progressive scarring of lung tissue, making it increasingly difficult to breathe), and acute pulmonary edema (a sudden buildup of fluid in the lungs). Record review of Resident #1's MDS Assessment, dated 04/09/26, reflected he received respiratory treatments both on admission and while a resident at the facility. Record review of Resident #1's Physician's Orders, dated 04/23/26, reflected an active PRN order for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 1 vial; inhale orally every 4 hours as needed for wheezing/shortness of breath [via nebulizer]. The start date for this order was 04/03/26. Record review of Resident #1's Care Plan, dated 03/30/26 (but active as of 04/23/26), reflected no evidence that Resident #1's order for treatment via nebulizer was included in the plan of care. Observation of Resident #1's nebulizer equipment on 04/23/26 at 9:22AM revealed his nebulizer mask and mouthpiece were not in use and were lying on his bedside table, unbagged. 2.) Record review of Resident #2's Face Sheet, dated 04/23/26, reflected she was a [AGE] year-old female, who was originally admitted to the facility on [DATE], with diagnoses including acute respiratory failure with hypoxia (a potentially life-threatening condition characterized by insufficient oxygen in the blood) and chronic obstructive pulmonary disease (progressive lung disease that makes it difficult to breathe). Record review of Resident #2's MDS Assessment, dated 04/05/26, reflected she received respiratory treatments both on admission and while a resident at the facility. Record review of Resident #2's Physician's Orders, dated 04/23/26, reflected an active PRN order for continuous oxygen at 2-4 L/Min via nasal cannula to maintain her oxygen stats > 92%. The start date for this order was 04/18/26. Record review of Resident #2's Care Plan, dated 02/25/26 (but active as of 04/23/26), reflected no evidence that Resident #2's order for continuous oxygen was included in the plan of care. Observation of Resident #2's oxygen equipment on 04/23/26 at 10:09AM revealed her oxygen tubing/nasal cannula was not in use and was lying on a chair, unbagged. During an interview with CNA A on 04/23/26 at 10:57AM, she confirmed observing Resident #1's nebulizer mask and mouthpiece, as well as Resident #2's oxygen tubing/nasal cannula, not in use and unbagged. CNA A stated nebulizer masks, nebulizer mouthpieces, and oxygen tubing/nasal cannulas should all be bagged when not in use. She stated the risk of not bagging the items included the potential for infection. During an interview with the DON on 04/23/26 at 11:40AM, he stated oxygen tubing/nasal cannulas, nebulizer masks, and nebulizer mouthpieces should all be bagged when not in use. He stated the risk of not bagging these items included the potential for infection. The DON stated it was the responsibility of every staff member to ensure respiratory equipment was appropriately bagged when not in use to prevent infection. During an interview with the DON and Administrator on 04/23/26 at 12:22PM, they stated they did not have a policy related to proper storage of respiratory equipment (such as oxygen tubing/nasal cannulas, nebulizer masks, and nebulizer mouthpieces).