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	04/17/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070 Based on observation, interview and record review, the facility failed to ensure that each resident has the right to privacy to be treated with respect, personal body privacy, and dignity during wound care for 1 of 4 residents (Resident #15) reviewed for respect, privacy and dignity in that: Each resident has the right to privacy and confidentiality for all aspects of care and services. A nursing home resident has the right to personal privacy of not only his or her own physical body, but of his or her personal space, including accommodations and personal care. The facility failed to ensure Treatment Nurse A provided privacy when providing Resident #15 with wound care. The facility failed to ensure Physical Therapist provided privacy and dignity when the Physical Therapist announced in front of Resident #15 to Treatment nurse A that she needed to go and care for another resident's wound because it was leaking blood through the dressing. This failure could place residents at risk of emotional distress and low self-esteem. Findings included: Record review of Resident #15's quarterly MDS dated [DATE] revealed a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included: Coronary Artery Disease (poor circulation), heart failure (heart cannot function well), Diabetes Mellitus (high blood sugar), and anemia. Resident #15 was alert and oriented and able to make decisions. Record review of Resident #15's care plan dated 04/10/2025 reflected the resident had a Diabetic Ulcer r/t Diabetes and an arterial ulcer to the left lower lateral leg. An observation on 04/15/2025 at 9:46 a.m., Treatment nurse A provided wound care to Resident #15's left lower later leg and calf, while he was in his bed. LVN E did not close the door or pull the privacy curtain of Resident #15's room during the entire process. Resident #15's wound care was visible to the hallway. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 04/15/2025 at 9:50 a.m. revealed the Physical Therapist entering the room without knocking or announcing his entrance. The Physical Therapist spoke to Treatment Nurse A as she was performing the wound care to the left leg of Resident #15. The Physical Therapist spoke about another resident's wound Resident #259, the wound bleeding, and how he could not treat her until the wound was treated. Treatment Nurse A answered the Physical Therapist's questions concerning when she could complete the other resident treatments, the Physical Therapist left the room, only to return moments later asking another question concerning the time of treatment of the other resident's wound. During an interview on 4/15/2025 at 11:00 a.m., Resident #15 stated he did not notice if the door and privacy curtain was not closed properly. He said he would be visible to others if the door and the curtain was not closed properly. Resident #15 did not comment when ask about the conversation between the Physical Therapist and Treatment Nurse A. During an interview on 04/15/2025 at 11:35 a.m. with Treatment Nurse A stated, by not closing the door and the curtain, the privacy and dignity of Resident #15 was compromised as anyone passed by the room could see the wound care. When asked about the training she received on resident's rights, Treatment Nurse A stated she was fully aware of resident right to have privacy, dignity, and respect and received in-service on resident's rights at least once a year. During an interview on 04/16/2025 at 12:37 p.m. with Physical Therapist revealed he was aware that what had happened in Resident #15's room on 04/15/2025 was inappropriate. He stated he should not have spoken to treatment Nurse A about another resident's wounds in front of another resident. The Physical Therapist had stated he had been in-serviced on resident rights, dignity, and privacy sometime in the past year. During an interview 04/17/2025 at 4:35 p.m., the DON stated privacy and dignity must be provided during nursing care and the door and privacy curtain to Resident #15 and room should have been closed completely by Treatment Nurse A. He said the training was ongoing process and resident rights was one of them. The DON stated the facility ensured all the new hires had gone through skill checks. Every nursing staff also had to complete an annual evaluation to ensure their nursing skills and knowledge including competency in respecting resident's rights. The DON stated this includes the Physical Therapist and the therapy department. The DON stated the Physical Therapist never should have entered the room unannounced and spoken another resident's conditions in front of another resident. During an interview on 04/17/24 at 4:30 p.m., the Administrator stated the residents' rights at the facility should be maintained during nursing care. She said staff was expected to respect privacy and dignity by making sure doors to rooms were closed, privacy curtains fully drawn, and the window blinds was shut properly. Review of facility's policy Resident Rights dated 2003, reflected: We believe each resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside our facility. We protect and promote the following rights of each resident. 8. Each resident is treated with consideration, respect, and full recognition of his/her dignity and individuality, including privacy in treatment and in care for personal needs

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070 Based on observation, interviews, and record reviews, the facility failed to ensure each resident was treated with a clean comfortable environment during care, to include clean linens to support their quality of life, recognizing each resident's individuality for 1 (Resident #15) of 4 residents. The facility failed to ensure Resident #15 was treated with respect, dignity, and care when they failed to ensure Resident #15's linens were clean and the soiled protective boots were removed from the room. This failure could place residents at risk for diminished quality of life, loss of dignity and self-worth, psychosocial harm and distrust with staff. Findings Included: Record review of Resident #15's quarterly MDS dated [DATE] revealed a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included: Coronary Artery Disease (poor circulation), heart failure (heart cannot function well), Diabetes Mellitus (high blood sugar), and anemia. Resident #15 was alert and oriented and able to make decisions. Record review of Resident #15's care plan dated 04/10/2025 reflected the resident had a Diabetic Ulcer r/t Diabetes and an arterial ulcer to the left lower lateral leg. Observation on 4/15/2025 at 9:46 a.m. revealed Resident #15 in his bed. The bottom linens on the bed had dried dark stains of reddish, brown, and yellow substance. Resident #15's feet were laid upon these stained linens. The bandage to Resident #15's left leg was soiled with dried dark, brown, red, and yellow substance. There were two sets of soiled protective boots piled up on the top of the [NAME] drawers in Resident #15's room. Interview on 4/15/2025 at 9:46 a.m., Treatment Nurse A stated she had found Resident #15's linens soiled on multiple occasions in the past two weeks, just like today. The Treatment nurse stated she had told the staff about it, but it had not changed. The Treatment Nurse A stated that she had come in a couple of mornings and found his leg stuck to the linens and she had to use the saline wound cleanser to soak the dressing away from the linens. Treat Nurse A stated she had told the Wound Care Physician and Resident #15's treatment had been recently changed and the wound was draining less. The Treatment Nurse also stated that she had told them multiple times to remove the soiled protective boots from his room, he no longer uses them. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/15/2025 at 11:00 a.m., Resident #15 stated he did not like his sheets to be dirty and he had told the staff and they would sometimes change him and sometimes not change him. Resident #15 stated when they did not change him, he did not complain to anyone else he just waited until someone came in that would change him. He stated the night shift was the shift that did not change him and then in the morning the day shift would change him after the nurse told them to. Resident #15 stated sometimes his leg would get stuck to the sheets and he was afraid to pull it because the dressing might come off, so he just would lie there. Resident #15 stated he had not had his linens changed since yesterday, when the dressing was changed yesterday. The resident stated the wound was draining less since the wound care physician, saw him last week and had changed the treatment to address the excessive drainage. The resident stated that the doctor had told him the wound was improving, but it would be better if the wound drained less. During an interview on 04/15/2025 at 12:30 p.m. with CNA B, who worked the day shift form 6:00 a.m. to 2:00 p.m., revealed the CNAs were moved around on different halls everyday they worked, they did not stay on the same hall everyday they worked. CNA B stated this was the first time she had worked with Resident #15 and his linens looked like that. CNA B stated Resident #15 had never complained to her about needing his sheets changed and the staff not doing it. An observation on 04/15/2025 at 1:15 p.m. revealed the soiled protective boots remained stacked up on the [NAME] drawers in Resident #15's room, as he sat and ate his lunch. During an interview on 04/16/2025 at 1:03 p.m. with Resident #15 revealed that the soiled protective boots had been removed from his room last night, but they had been stacked up on the dresser for about two weeks, until [you], the Surveyor said something about them. During an interview on 04/16/025 at 12:30 p.m. with LVN C revealed when a resident had soiled dressing that was draining, it should be changed when it is reported. LVN C stated any prudent nurse would change the dressing, not repeat the treatment, but change the soiled dressing and the soiled linens. LVN C was not aware that Resident #15 had a history of the wound draining or the dressing sticking to the linens. LVN C stated it would be uncomfortable to have a draining wound and your dressing stuck to the linens. During an interview on 04/16/2025 at 1:12 p.m. with LVN G revealed if a resident had dressing on their body that was soiled and needed to be changed, any nurse could change the dressing, they do not need an order do that. LVN G stated you would want to let the wound care nurses know that the wound was draining, so they could communicate that to the wound care physician. During an interview on 04/16/2025 at 2:20 p.m. with CNA F revealed if the resident's linens were soiled then they need to be changed. CNA G stated occasionally Resident #15 had soiled linens from the wound on his leg. The CNA would change the linens. CNA G stated she would let the nurse know the leg was draining. The CNA stated she had only seen his sheets soiled from the drainage a couple of times, but she did not work on his all every day, they work on different halls every day they work. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/2025 at 4:35 p.m., the DON stated privacy and dignity must be provided during nursing care and the door and privacy curtain to Resident #15 and room should have been closed completely by Treatment Nurse A. He said the training was ongoing process and resident rights was one of them. The DON stated the facility ensured all the new hires had gone through skill checks. Every nursing staff also had to complete an annual evaluation to ensure their nursing skills and knowledge including competency in respecting resident's rights. The DON stated this included the linens of the residents should be changed when they are soiled, as well as dirty items that are left in the residents rooms, they should all be removed. During an interview on 04/17/24 at 4:30 p.m., the Administrator stated the residents' rights/dignity at the facility should be maintained during nursing care. She said staff was expected to protect dignity, including the cleanliness of the resident's items that they were using and their clothing, as well as their linens on their bed. This could affect the quality of the resident's life. Review of facility's policy Resident Rights dated 2003, reflected: We believe each resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside our facility. We protect and promote the following rights of each resident. 8. Each resident is treated with consideration, respect, and full recognition of his/her dignity and individuality, including privacy in treatment and in care for personal needs

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44021 Based on observation interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistive devices to prevent accidents for three of three residents (Residents #7, #26, and #198) reviewed for accidents and hazards. The facility failed to properly maintain wheelchair armrests for Residents #7, #26, and #198 These failures could place residents at risk for equipment that is in unsafe operating condition, which could cause injury. Findings included: 1. Record review of Resident #7's quarterly MDS assessment, dated 02/18/25 reflected a [AGE] year-old female who had been initially admitted to the facility on [DATE]. Resident #7 had diagnoses that included Cerebrovascular Accident (stroke), Alzheimer's Disease, Dementia, repeated falls, and unsteadiness on feet. Record review of Resident #7's plan of care, dated 02/25/2025, reflected goals and approaches to include wheelchair mobility for locomotion. Observation and interview on 04/15/2025 at 11:43 AM revealed Resident #7 was sitting in a wheelchair at a dining table. Resident #7 was wearing long sleeves, but the resident indicated that she had no skin problems. The wheelchairs' left armrest was missing some of the vinyl covering and some of the interior stuffing could be seen. The wheelchairs' right armrest was loosely secured to the wheelchair by silver fibrous tape and clear cellophane tape. The vinyl covering appeared to be split and most of the cushion material appeared to be missing. Resident #7 indicated that she would like to have a new wheelchair armrest. 2. Record review of Resident #26's quarterly MDS assessment, dated 03/22/2025 reflected an [AGE] year-old female who had initially admitted to the facility on [DATE]. Resident #26 had diagnoses that included Coronary Artery Disease, Heart Failure, Alzheimer's Disease, Dementia, and Repeated Falls. Record Review of Resident #26's plan of care, dated 04/07/2025, reflected goals and approaches to include wheelchair mobility for locomotion. Observation and interview on 04/15/2025 at 11:52 AM revealed Resident #26 was sitting in a wheelchair next to a dining room table. Resident #26 was wearing a short sleeve shirt and actively moving her arms, the skin on her arms appeared intact. The left arm rest on Resident #26's wheelchair was split open on the left side and the cushion material from inside of the armrest was hanging down over the side of the armrest. The resident was unable to answer any questions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of Resident #198's MDS quarterly MDS Assessment, dated 02/19/2025 reflected an [AGE] year-old female that had initially admitted to the facility on [DATE]. Resident #198 had diagnoses that included Alzheimer's Disease, Dementia, and Unsteadiness on Feet. Record Review of Resident #198's plan of care, dated 1/30/2025 reflected goals and approaches to include wheelchair mobility for locomotion. Observation and interview on 4/16/2025 at 11:48 AM Resident #198 was sitting in a wheelchair next to a dining room table. Both wheelchair armrests were observed to have the vinyl covering on them to be cracked with sharp edges pointed upwards. The resident stated that she had no wounds or scratches on her arms. She stated that she would like new armrests but denied that she had asked anyone about it. In an interview on 04/17/2025 at 2:30 PM, CNA D stated when a resident's wheelchair needed repair the staff were to enter it into the electronic maintenance system in an app on their phones. CNA A stated she had never wrote anything in the phone app about residents wheelchairs that might have needed repair. In an interview on 04/17/2025 at 2:41 PM, CNA E stated when a resident's wheelchair needed repair the staff were to write it in the electronic maintenance system, tell the maintenance man, who would tell them to place the information in electronic maintenance system. In an interview on 04/17/2025 at 3:02 PM, the Director of Rehab stated that her department repaired wheelchair armrest whenever they saw damaged armrests that may cause discomfort to the resident. She stated that the Rehab Department staff always kept their eyes open for wheelchairs that might need repairs for residents that were currently receiving rehabilitation services and residents that were not currently receiving rehabilitation services. In an interview on 04/17/2025 at 3:12 PM, the Maintenance Supervisor stated he repaired the wheelchairs when there was needed repairs. He stated that generally the Rehabilitation Department did most of the wheelchair maintenance. A record review of the facility's policy and procedure Maintenance, dated July 2018, reflected It is the policy of this community to maintain all equipment provided by the facility, in good working order to ensure the safety and wellbeing of all residents and staff . Equipment provided by the community will be: 1. Maintained in working order.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50948 Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety. 1. The facility failed to ensure dented cans were placed in a separate storage area. 2. The facility failed to ensure food items were discarded by the use by date. These failures could place residents at risk for food-borne illness and cross contamination. Findings Include: Observation of the refrigerator on [DATE] at 9:47am revealed the following: -3 1-gallon milk with a use by date [DATE]. Observation of the dry storage on [DATE] at 9:55am revealed the following: -1 6lb 10oz can of spaghetti sauce dated [DATE] was dented on top right and top left. -1 6lb can of mushrooms dated [DATE] was dented on front bottom and front left. -1 6lb 10oz can of pumpkin dated [DATE] was dented on top right. -1 8lb 4oz can of apple jelly dated [DATE] was dented on top back. Interview with the DM on [DATE] at 11:15am she stated it was the kitchen staff responsibility to sort through food items and properly label and store food items once received from the vendor. She stated dented cans was stored in a separate area in the dry storage. She stated dented cans was identified and returned to the vendor. She stated dented cans could go bad and cause foodborne illnesses. She stated milk that had a use by date did not mean the milk was expired. She stated the kitchen staff must inspect the milk when it passed the use by date to make sure the milk was still good. She stated the expired milk was discarded just to be safe. She stated expired milk could make residents sick. In an interview with [NAME] H on [DATE] at 11:20am she stated once food items were delivered by the vendor, it was the kitchen staff responsibility to inspect food items. She stated dented cans were not stored in the kitchen, and dented cans was returned to the vendor. She stated the metal inside dented cans could cause food poison. She stated residents could get sick from expired milk.