STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455563	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denison Nursing and Rehab	601 E Hwy 69 Denison, TX 75021

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 32486 Based on interview and record review the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for two (CNA C and the DON) of five employees reviewed for abuse and neglect. 1.The facility failed to conduct CNA C's Employee Misconduct Registry (EMR)/Nurse Aide Registry (NAR) check annually. 2.The facility failed to conduct the DON's Employee Misconduct Registry (EMR)/Nurse Aide Registry (NAR) check upon hire. These failures could place residents at risk for abuse and receiving care from unemployable staff. Findings included: Review of the facility's policy on 03/04/25, revised April 2021, titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: a. facility staff . 4. Conduct employee background checks and not knowingly employ otherwise engage any individual who has b. had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation mistreatment of residents or misappropriation of their property . (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy on 03/05/25, revised March 2019, titled, Background Screening Investigations: Our facility conducts employment background screening checks, reference checks and criminal conviction investigation checks on all applicants for positions with direct access to residents (direct access employees). 1. For purpose of this policy direct access employee means any individual who has access to a resident or patient of a long-term care facility .and has duties that involve one-on-one contact with a patient or resident of the facility or provider .2 .Background and criminal checks are initiated within two days of an offer of employment .and completed prior to employment. 3. For any individual applying for a position as a certified nursing assistant, the state nurse aide registry is contacted to determine if any findings of abuse, neglect, mistreatment of individuals, and/or theft of property have been entered into the applicant's file . 1.Review of CNA C 's personnel records on 03/04/25 revealed a hire date of 10/01/23. There was no documentation the annual EMR/NAR registry check was conducted for October 2024. 2. Review of the DON's personnel records on 03/04/25 revealed a hire date of 10/16/24.There was no documentation for the DON's EMR/NAR registry check initiated within two days of an offer of employment or prior to employment. Interview with the ADM on 03/04/25 at 12:49 PM revealed the ADM was responsible for checking the EMR/NAR for all employees. The ADM stated the EMR/NAR checks should be completed upon hire and annually to ensure the employees were employable. The ADM stated she could not find an EMR/NAR check for CNA C for October 2024 in her employee file. The ADM stated she did not check the DON on the EMR/NAR upon hire that was her mistake. The ADM stated it was important to check all facility employees on the EMR/NAR to ensure all employees are employable and to prevent abuse. The ADM completed EMR/NAR checks on CNA C and the DON which reflected they were employable on 03/04/25 before the surveyor exited the facility.

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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** 32486 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for one (Resident #1) of five residents whose care plans were reviewed, in that: The facility failed to revise Resident #1's care plan to accurately reflected current tube feeding status as of 02/27/25. These failures could place residents at risk of receiving inadequate individualized care and services. Findings included: Review of Resident #1's face sheet dated 03/04/25 revealed a [AGE] year-old male who was originally admitted to the facility on [DATE] with a current admitted [DATE]. Resident #1's diagnoses included the following: pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid), acute respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), dementia (a group of thinking and social symptoms that interferes with daily functioning), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), dysphagia (difficulty swallowing) and autistic disorder (developmental disability that affects how a person communicates, interacts with others, learns and behaves). Review of Resident #1's significant change in status MDS assessment dated [DATE] revealed Resident #1 had unclear speech, was rarely/never understood and rarely/never understood others. Resident #1 had a BIMS score of 99 indicating Resident #1 was unable to complete the interview. Record review of Section K - Swallowing/Nutritional Status reflected that Resident #1 had loss of liquids/solids from mouth when eating or drinking and received a mechanically altered diet. Resident #1's quarterly/Medicare 5-day MDS assessment dated [DATE] was in progress and section K- Swallowing/Nutritional Status was incomplete at the time of investigation exit on 03/05/25. Review of Resident #1's care plan retrieved 03/04/25 revealed it did not address his newly placed peg tube (a thin flexible tube inserted through the abdominal wall directly into the stomach). Review of Resident #1's hospital discharge orders/instructions revealed discharge request date of 02/27/25, procedure performed-surgical procedure on 02/16/25 for peg placement (a minimally invasive surgical procedure that involves inserting a feeding tube directly into the stomach through a small incision in the abdominal wall). Observation on 03/04/25 at 1:24 PM revealed Resident #1 was observed to be lying in his bed with head of bed elevated and TF order infusing as ordered. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/04/25 at 9:07 AM with the ADM revealed Resident #1 was a long-term resident who had recently had a change of condition and was sent to the hospital as a result of the change on 02/11/25 and returned on 02/27/25 requiring tube feeding. Interview on 03/04/25 at 10:17 AM with the DON revealed Resident #1 returned from the hospital on 02/27/25 with an order of NPO and his nutritional needs were being met via tube feeding now. Interview on 03/04/25 at 10:53 AM with CNA D revealed Resident #1 returned from the hospital NPO and with a tube feeding. Interview on 03/04/25 at 11:07 AM with CNA C revealed Resident #1 returned from the hospital NPO and with a tube feeding. Interview on 03/04/25 at 1:24 PM with the DON revealed she was responsible for updating the resident care plans. The DON confirmed that Resident #1's care plan was not updated appropriately upon his return from hospitalization on [DATE] to reflect his nutritional needs were completely being met by tube feeding. The DON stated she was previously not responsible for updating the care plans and she honestly forget to update Resident #1's to reflect his current tube feeding status. The DON stated that it was important to keep the care plan updated to ensure the appropriate services and care are provided to the residents. Interview on 03/05/25 at 12:49 PM with the ADM revealed the DON would have been responsible for ensuring Resident #1's care plan was updated upon his return from the hospital to reflect the change in his nutritional status from PO to NPO. The ADM stated her expectation was for Resident #1's care plan to reflect Resident #1's tube feeding. The ADM stated it was important for the care plan to reflect a resident's condition accurately. Review of facility's policy titled, Goals and Objectives, Care Plans with a revised date of April 2009 revealed Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. 5. Goals and objectives are reviewed and/or revised: a. When there has been a significant change in the resident's condition .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32486 Based on interview and record review the facility failed to ensure that a resident who was fed by gastrostomy tube received the appropriate treatment and services to prevent complications of enteral feeding for one (Resident #1) of one resident reviewed for gastrostomy tube feedings. LVN A failed to transcribe Resident #1's bolus feeding order upon hospital return on 02/27/25. This failure could place residents who received gastrostomy tube feedings at risk for not receiving the intended therapeutic benefit as ordered. Findings included: Review of Resident #1's face sheet dated 03/04/25 revealed a [AGE] year-old male who was originally admitted to the facility on [DATE] with a current admitted [DATE]. Resident #1's diagnoses included the following: pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid), acute respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), dementia (a group of thinking and social symptoms that interferes with daily functioning), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), dysphagia (difficulty swallowing) and autistic disorder (developmental disability that affects how a person communicates, interacts with others, learns and behaves). Review of Resident #1's significant change in status MDS assessment dated [DATE] revealed Resident #1 had unclear speech, was rarely/never understood and rarely/never understood others. Resident #1 had a BIMS score of 99 indicating Resident #1 was unable to complete the interview. Record review of Section K - Swallowing/Nutritional Status reflected that Resident #1 had loss of liquids/solids from mouth when eating or drinking and received a mechanically altered diet. Resident #1's quarterly/Medicare 5-day MDS assessment dated [DATE] was in progress and section K- Swallowing/Nutritional Status was incomplete at the time of investigation exit on 03/05/25. Review of Resident #1's care plan retrieved 03/04/25 revealed Resident #1's only problem related to having a tube feeding was related to his medications: Problem resident requires having his medication crushed and put via peg tube. Resident is NPO. Resident #1's care plan did not address a problem related to having bolus feeding which included a goal or interventions. Review of Resident #1's progress note dated 02/27/25 written by LVN A revealed resident arrived via ambulance at 5:00 PM this day .Peg tube (a thin, flexible tube inserted through the abdominal wall directly into the stomach) in place to lower upper quadrant. Supplies do not fit feeding pump and end on peg tube, notified DON and called MD for new order for the bolus feedings until supplies get here for the feeding pump and end bolus once supplies arrive. New order Jevity 1.5 via peg tube 750 cc via gravity over 15 minutes .If resident tolerating bolus and water amounts continue feedings every 4 to 6 hours. If resident distress during feedings goes to 30 minutes. Record review of Resident #1's electronic physician orders for February 2025 revealed no order for bolus feeding/gravity feeding of Jevity 1.5 via peg tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's electronic MAR for February 2025 revealed no documentation for bolus feeding/gravity feeding of Jevity 1.5 via peg tube for 02/27/25 or 02/28/25. Interview on 03/04/25 at 1:24 PM with the DON revealed the verbal hospital discharge report for Resident #1 was taken by LVN A which was reported to be Jevity 1.5 at 45 ml/hr times 22 hours via peg tube pump. The DON stated she reviewed the actual hospital discharge paperwork, and it did not state a TF order in the discharge orders. The DON stated the facility did not have the appropriate tubing for Resident #1's tube feeding port attachment site once Resident #1 readmitted , therefore the DON stated LVN A called to obtain bolus feeding orders for Resident #1 from Dr. B until the appropriate tubing arrived for the Jevity feeding pump order. The DON stated she expected LVN A to transcribe the bolus feeding order for Resident #1 since she was Resident #1's admitting nurse on 02/27/25. The DON stated that Resident #1 did receive his bolus feeding on 02/27/25 and 02/28/25 however there was no documentation on Resident #1's MAR since the bolus feeding order was not transcribed by LVN A. The DON stated she expected all orders including verbal orders to be transcribed into the electronic physician orders and recorded on the electronic MAR. The DON stated not transcribing bolus feeding orders could result in a resident receiving an incorrect tube feeding rate which could result in changes to a resident's nutritional status. Interview on 03/04/25 at 1:55 PM with LVN A revealed she readmitted Resident #1 back to the facility on [DATE] at about 5:00 PM. The nurse said when she had received the resident's information from the hospital via telephone it was reported the resident had been receiving feeding via g-tube. LVN A said when Resident #1 arrived at the facility there had been nothing in the hospital orders about g-tube feedings. The LVN A said she had not felt comfortable starting the feeding without an order and there was an issue with the feeding tubing and the port connection site therefore she contacted the DON. LVN A called Dr. B and obtained an order for bolus feeding per the DON suggestion until the correct tubing was obtained. LVN A stated that Dr. B provided an order of Jevity 1.5 via peg tube 750 cc via gravity every 4-6 hours and to monitor the resident's tolerance to the bolus feedings. LVN A stated she should have transcribed the bolus feeding order for Resident #1 but she forgot therefore it did not appear on Resident #1's MAR. LVN A stated that all orders including verbal orders are to be transcribed so medications and treatments can be given correctly according to order and documented appropriately. LVN A stated not transcribing a bolus feeding order could result in adverse changes to a resident's nutritional status. Interview on 03/05/25 at 12:49 PM with the ADM revealed LVN A was Resident #1's admitting nurse on 02/27/25 and was responsible for ensuring all orders were transcribed. ADM stated the importance of transcribing orders correctly was to ensure care and services were provided and documented accurately. Review of facility policy titled, Medication and Treatment Orders with a revised date of July 2016 revealed Orders for medications and treatments will be consistent with principles of safe and effective order writing. 2. Only authorized, licensed practitioners, or individuals authorized to take verbal orders from practitioners, shall be allowed to write orders in the medical record. 7. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and the time of the order . Review of the facility policy titled, Enteral Nutrition with a revised date of November 2018 revealed Adequate nutritional support through enteral nutrition is provided to residents as ordered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32486 Based on observation, interview and record review the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments and permit only authorized personnel to have access to the keys for one (cart E, cart for rooms 124-143) of two medication carts reviewed. LVN A failed to lock medication cart E (cart for rooms 124-143) on 03/04/25. This failure could place residents at risk for possible drug diversions. Findings included: Observation on 03/04/25 at 8:40 AM revealed medication cart E at the nursing station near room [ROOM NUMBER] was unlocked and unattended for approximately 2 minutes. All drawers of the medication cart could be opened, and the medications were easily accessible. Resident #2 was in her wheelchair right next to the unattended cart. LNV A was observed not to be on the hallway and not within line of slight of the cart. Interview and observation on 03/04/25 at approximately 8:43 AM with LNV A revealed medication cart E was unlocked, LVN A stated she was away from her cart off the hallway looking for the ombudsman posting. LVN A stated she had been away from her cart just a few minutes. LVN A stated the cart needed to be locked and secure to prevent a drug diversion and theft. LVN A stated she knew she was responsible for keeping the cart locked. Interview on 03/04/25 at 9:24 AM with the ADM revealed medication carts should be locked when the nurse leaves the cart unattended. The ADM stated the medication cart needs to be locked to ensure medication security. The ADM stated leaving a medication cart unlocked could result in a drug diversion or theft. Interview on 03/04/25 at 10:42 AM the DON stated the medication cart was to be locked while unattended. The medication cart needed to be secured to prevent anyone from gaining access to the medications, which could result in the theft of medications or a drug diversion. Review of the facility policy titled, Medication Labeling and Storage, revised February 2023, revealed The facility stores all medications and biologicals in locked compartments .Only authorized personnel have access to keys. 4. Compartments (including, but not limited to, drawers, cabinets .carts and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Security of Medication Cart, revised April 2007, revealed The medication cart shall be secured during medication passes. 1. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry. 4. Medication carts must be securely locked at all times when out of the nurse's view. 5. When the medication cart is not being used, it must be locked and parked at the nurses' station or inside the medication room. Review of the facility policy titled, Storage of Medications, revised November 2020, revealed The facility stores all drugs and biologicals in a safe, secure, and orderly manner. 6 .Unlocked medications are not left unattended.