

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455563	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER Denison Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690</p> <p>Based on 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 1 (Resident #1) of 1 resident whose care plan was reviewed, in that:</p> <p>The facility failed to develop a comprehensive care plan for Resident #1.</p> <p>This failure could place residents at risk of receiving inadequate individualized care and services.</p> <p>Findings included:</p> <p>Review of Resident #1's admission MDS assessment dated [DATE] reflected Resident#1 was admitted to the facility on [DATE] with diagnoses of dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), diabetes mellitus (elevated blood sugar), and heart failure. Resident#1 had a BIMS score of 12 indicating he was moderately cognitively intact.</p> <p>Review of Resident #1's care plan revealed no care plan was in the system (PCC) for Resident#1 as of 04/10/25.</p> <p>Interview on 04/10/25 at 11:35 AM with the DON, she stated Resident#1 should have a care plan since he was admitted on [DATE]. She stated she will check the PCC, after checking the PCC, the DON stated there was no care plan for Resident#1.</p> <p>Interview on 04/10/25 at 12:22 PM over the phone with the MDS coordinator, she stated Resident#1 care plan was done on 3/04/2025, and it was in the system (PCC). The MDS coordinator further stated she does not know what happened and she thought it was deleted. She stated all residents must have a care plan to make sure their needs were meet.</p> <p>Follow up interview on 04/10/25 at 12:29 PM with the DON, she stated the MDS coordinator was responsible for uploading the resident care plans, and she as a DON does the intervention. She stated the care plan was needed so the appropriate services and care are provided to the residents.</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility's policy titled, Care Planning-Interdisciplinary Team with a revised date of September 2013 revealed Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive Care plan for each resident . 1. A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS) .</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690</p> <p>Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 (Resident #2) of 1 resident reviewed for ADL's.</p> <p>The facility failed to ensure Resident#2 had his fingernails trimmed and cleaned.</p> <p>This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life.</p> <p>Findings include:</p> <p>Record review of Resident #2's Quarterly MDS assessment dated [DATE] reflected Resident#2 was a [AGE] year-old male admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including muscles weakness, dementia (diseases that affect memory, thinking, and the ability to perform daily activities), and hypertension (High blood pressure). He had a BIMS score of 06/15 indicating severe cognitive impairment. He was total dependent with personal ADLs.</p> <p>Record review of Resident #2's Comprehensive Care Plan last revised 04/10/25 reflected the following Focus. Resident #2 has and ADL self-care performance deficit r/t dementia, Goal. The resident#2 will maintain current level of function through next review. Intervention. BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse .</p> <p>Observation/Interview on 04/10/25 at 07:57 AM revealed Resident#2 was lying in bed. Resident#2 had long fingernail approximately 0.7 cm on both hands, with clear brown matter underneath. Resident#2 was asked if he want his fingernail trimmed and cleaned, he replied yes.</p> <p>Interview on 04/10/25 at 08:35 AM with CNA A, CNA A looked at Resident#2 fingernail and stated they were long and some of them were dirty underneath. CNA A stated Resident#2 fingernails needed to be cleaned and trimmed. CNA A further stated the risk to the residents they could scratch them self, and development of infection.</p> <p>Interview on 04/10/25 at 09:50 AM with LVN B, she stated both CNAs and charge nurses in the Halls were responsible for residents' nail care. She stated if a resident had diabetes, only nurses were allowed to trim resident's nails. She stated the risk for not performing nailcare was increased risk of infection and skin break down.</p> <p>Interview on 04/10/25 at 11:35 AM with the DON, she stated her expectation was that nail care should be provided every shower day and as needed. She stated that both CNAs and charge nurses were responsible for doing nail care on all residents; except Nurses were responsible for nailcare if resident had diagnosis of diabetes. The DON stated residents who had dirty fingernails could be an infection control issue.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record Review of the facility policy titled Nail Care-Fingernails and Toenails, revised September 13, reflected, Purpose: 1. To promote cleanliness 2. To prevent injury 3. To prevent infection The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690</p> <p>Based on observations, interviews, and record review the facility failed to ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 1 of 1 Resident (Resident#1) reviewed for pharmacy services.</p> <p>The facility failed to ensure Resident#1 did not have his morning medications (Allopurinol, Aspirin, Glimpiride, Isosorbide, metoprolol, Nifedipine, Plavix, Potassium, Torsemide, Calcium Carbonate -Vit D with min, and Gabapentin) left on the bedside table on 04/10/25.</p> <p>These failures could place residents at risk of medication misuse, not receiving physician ordered medications which could result in non-therapeutic treatments or injuries.</p> <p>Findings Included:</p> <p>Record review of Resident # 1's face sheet dated 04/10/25 reflected a [AGE] year-old male with an admitted [DATE]. Diagnoses included dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain)</p> <p>diabetes mellitus (elevated blood sugar), and heart failure.</p> <p>Record review of Resident #1's Physician orders summary sheet dated 04/10/25 reflected, Allopurinol oral tablet 300 mg Give 1 tablet by mouth in the morning; Aspirin oral tablet 81 mg Give 1 tablet by mouth in the morning; Glimpiride oral tablet 4 mg Give 1 tablet by mouth in the morning; Isosorbide oral tablet 60 mg Give 1 tablet by mouth in the morning; Metoprolol oral tablet 50 mg Give 1 tablet by mouth in the morning; Nifedipine oral tablet 30 mg Give 1 tablet by mouth in the morning; Plavix oral tablet 75 mg Give 1 tablet by mouth in the morning; Potassium oral tablet 10 mEq Give 1 tablet by mouth in the morning; Torsemide oral tablet 20 mg Give 1 tablet by mouth in the morning; Calcium Carbonate -vit D-Min Oral Tablet 600-200 mg-unit Give 1 tablet by mouth in the morning; Gabapentin oral tablet 300 mg Give 1 tablet by mouth in the morning. With a start date of 02/25/25.</p> <p>In an observation and interview on 04/10/25 at 07:44 AM revealed Resident#1 sitting up in bed, alone in his room. A medication cup with his name full of medications tablets in different forms and colors (11 in total) was observed on the bedside table. Resident #1 stated the nurse left the medications for him to take. He stated he will take his medications.</p> <p>In an observation/interview with LVN B on 04/10/25 at 07:49 a.m. she looked at the medications cup and told Resident#1, that he needed to take his medication. She stated she gave the medications to Resident#1 this morning and had to go to open the facility door and forgot to come back and check on the resident to see if he took his medications. She stated the risk to resident was that he could miss his morning medication if another resident walked to the room and took the medication. She stated the unattended medications could cause harm to another resident if he/she took them.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/10/25 at 11:35 AM with the DON she stated the resident medications should not be left unattended, or at the bed side table. She stated the nurses were training to give resident their medications, and make sure the resident swallow the medications before the nurse leave the room. The DON stated the unattended medications could cause harm to Resident#1 if he missed his morning dose and could harm another resident if he/she took the medication and was allergic to any one of them.</p> <p>Record review of the facility policy Medication Labeling and Storage, revised February 2023, revealed The facility shall store all drugs and biologicals in a safe, secure, and orderly manner .</p>