

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 05/16/2025
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 0575</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency.</p> <p>Based on observation and interview, the facility failed to post the Health and Human Services Commission (HHSC) complaint number and a statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of a state or federal regulation, including but not limited to resident abuse, neglect, exploitation, and misappropriation of property for 1 of 7 mandatory postings.</p> <p>The facility failed on 05/14/2025 to ensure the required posting (signage) of a HHSC complaint number and statement about how a resident may file a complaint with the State Survey agency.</p> <p>This failure placed residents at risk of being unaware of who and how to contact the State Survey Agency and their right to file a complaint with the State Service Agency concerning any suspected violation of state or federal regulation.</p> <p>The findings included:</p> <p>An observation throughout the facility on 05/14/25 at 10:40 AM, revealed there was no HHSC complaint number and statement that the residents may file a complaint with the State Survey Agency posted in any location of the facility.</p> <p>In an interview with the Administrator on 05/14/25 at 10:48 AM, who stated the postings was not posted in the facility. Administrator stated she did not pay attention to what was posted on the walls. She stated she did not know why there was no HHSC complaint number and statement that the resident may file a complaint with the State Survey Agency posted in the facility. Administrator stated it was important to have this signage posted so residents will know how to file a complaint regarding staff. The Administrator said the risk to the residents would be unreported abuse and neglect.</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>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** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-center plan that includes services that are furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being for one of twenty-eight (Resident #2) reviewed for care plans.</p> <p>The facility failed to update Resident #2's care plan to reflect elopement risk.</p> <p>These failures could affect residents by placing them at risk for not receiving care and services to meet their needs.</p> <p>Findings included:</p> <p>Review of Resident #2's face sheet reflected that the resident was a [AGE] year-old woman admitted on [DATE] with diagnoses of fracture of unspecified part of neck of right femur, type 2 diabetes, cerebral infarction, hyperlipidemia, spinal stenosis, dementia, anxiety disorder, glaucoma, anemia, hypertension, and rheumatoid arthritis.</p> <p>Records review of Resident #2's annual Minimum Data Set assessment dated [DATE] reflected that resident's Brief Interview for Mental Status (BIMS) score was 3 meaning the resident was severely cognitively impaired. Section G (Functional Status) for Activities of Daily Living Assistance reflected that Resident #2 required extensive assistance resident involved in activity, staff provide weight-bearing support, two+ person physical assist.</p> <p>Records review of Resident #2's care plan dated 04/25/2025 reflected no care plan for elopement.</p> <p>Records review of Resident #2's elopement risk assessment dated [DATE] reflected a score of 14, categorized as a high risk to wander.</p> <p>Review of a progress note entered on 5/12/2025 at 5:00 (am or pm not specified) reflected that Resident #2 stated she had to leave soon and go home and was going through drawers in her room gathering her belongings.</p> <p>Observation of Resident # 2 on 05/13/25 at 5:30 PM revealed resident was sitting in the dining room in a wheelchair.</p> <p>The surveyor attempted interview with DON about care plans on 05/14/25 at 9:27am. The DON's voicemail box was full and unable to leave a message. The DON did not call back by the date and time of exit on 05/16/25 at 4:30pm</p> <p>Interview with the MDS Coordinator on 05/15/25 at 10:11 am revealed Resident # 2 did not have a care plan for elopement.</p> <p>(continued on next page)</p>

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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 the facility provided policy on Wandering and Elopements revised March 2019 reflected If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety .</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for one of two (Resident #1) residents reviewed for elopement:</p> <p>The facility failed to prevent Resident #1's elopement through a window in an unoccupied room on [DATE] which resulted in resident being found two houses from the facility and facility staff being unaware that he had eloped.</p> <p>These failures resulted in an Immediate Jeopardy (IJ) on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of no harm with a scope identified as isolated.</p> <p>These failures negatively affected the residents and placed all residents at risk of injury or harm by not having a safe and secure facility.</p> <p>Findings included:</p> <p>Review of Resident #1's face sheet reflects that resident was a [AGE] year-old man admitted on [DATE] with a diagnosis of epilepsy, dementia, lack of coordination, sequelae of cerebral infarction, dysphagia, dysarthria, hypertension, heart failure, bipolar disorder, depression, hemiplegia and hemiparesis, hyperlipidemia, and hyponatremia. Records review reflect that Resident #1 was deceased [DATE] and discharged from the facility.</p> <p>Records review of Resident #1's quarterly Minimum Data Set assessment dated [DATE] reflected that resident's Brief Interview for Mental Status (BIMS) score was 12 meaning the resident was cognitively intact. Section GG0170 (Mobile Devices) reflects that resident used a wheelchair for mobilizing.</p> <p>Records review of Resident #1's elopement risk assessment dated [DATE] reflected a score of 12, categorized as a high risk to wander. The comments/notes reflected Resident #1 has verbally stated he wanted to leave.</p> <p>Review of Resident #1's care plan, initiated on [DATE], reflected a focus area for dementia and elopement risk. Review revealed the resident was at risk for wandering/elopement related to a history at previous facility and dementia diagnosis. The interventions were to identify pattern of wandering: was wandering purposeful, aimless, or escapist, was resident looking for something, does it indicate the need for more exercise, and intervene as appropriate.</p> <p>Records review of Resident #1's progress notes reflected a behavior note dated [DATE], stating that the resident got agitated during morning smoke break when only allowed one cigarette per smoke break and stated well, I am going to start walking the highway. Resident then forcefully got out of the smoking area door and forced staff to give him his second cigarette and not following commands or redirections.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Records review of the Provider Investigation Report dated [DATE] reflected at 5:00 pm during routine rounds by the CNA E, Resident #1 was not in his room and his wheelchair was inside his room. The resident eloped and staff found the resident walking on the side of the road behind the building approximately 2 houses down. The resident reported he climbed out the window in room [ROOM NUMBER] trying to go to his Family Member's house. The report further read the resident was assessed at 6:00pm and there was a minor scratch on his knee from climbing out the window.</p> <p>Review of the World Weather website reflected that the temperature on [DATE], the date of Resident #1's elopement, reflects that the high was 55 degrees Fahrenheit and the humidity 81%.</p> <p>During an interview on [DATE] at 10:18am, the Administrator revealed Resident #1 expressed he wanted to visit his family member when he was found. The Administrator stated Resident #1 did not exhibit elopement or exit seeking tendencies prior to the incident. The Administrator stated Resident #1 wandered in/out of rooms prior to the incident but not the facility. The Administrator stated elopement interventions were not put in place prior because Resident #1 was content when staff contacted his Family Member whenever he expressed, he wanted to see him. The Administrator stated the police were not contacted during the elopement incident because Resident #1 was missing for only 5 minutes. The Administrator stated the risk of elopement could be injury, death, or traffic challenges. The Administrator stated there was no reason why elopement drills were not conducted after the incident. The Administrator revealed details of resident elopement risk assessments were not made known to her.</p> <p>An interview and observation on [DATE] at 10:40 am with the Maintenance Director revealed Resident #1 was in room [ROOM NUMBER] separated by a shared bathroom with room [ROOM NUMBER]. There was no resident in room [ROOM NUMBER] at the date and time of elopement. Observation of room [ROOM NUMBER] revealed a locked window and a screen. Observation of Resident #2's room revealed a missing window screen. The Maintenance Director stated there are 8 windows without screens and he stated he was unsure if screens were ordered by the owners.</p> <p>During an interview on [DATE] at 8:16 am, CNA E stated she last saw Resident #1 at 4:30pm after the smoke break. CNA E stated Resident #1 was not in his room when she attempted to give him his dinner tray. CNA E stated she asked LVN I if she had seen the resident and when she had not, they searched for the resident. CNA E stated she noticed Resident #1's wheelchair in front of the window in the adjoining unoccupied room next to his room, separated by the bathroom. CNA E stated the window was closed and the screen was out. CNA E stated LVN I exited the back door and found Resident #1 at the end of the driveway. CNA E stated Resident #1 was asked where he was going, and he replied to his Family Member house.</p> <p>During an interview [DATE] at 3:58pm, LVN J stated Resident #1 expressed he wanted to go home and pointed his finger and stated, it's right over there. LVN J stated she was informed Resident #1 wandered by taking the screen out of the window and climbed out.</p> <p>During an interview [DATE] at 9:29am, CNA F stated she worked the day of the incident and stated Resident #1 was not in the dining room nor in his room when CNA E attempted to pass the dinner tray. CNA F stated CNA E and LVN I searched the facility for Resident #1. CNA F stated LVN I found resident #1 outside. CNA F stated she was not in-serviced on any topic after the incident.</p> <p>Records review of in-services on abuse and neglect and elopement dated [DATE], reflected the absence of CNA F's signature for participation.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility provided policy on Wandering and Elopements revised [DATE] reflected If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety .If a resident is missing, initiate the elopement/missing resident emergency procedure. If the resident is not located, notify the administrator and the director of nursing services, the resident's legal representative, the attending physician, law enforcement official, and (as necessary) volunteer agencies (i.e., emergency management, rescue squads, etc.).</p> <p>Review of the facility-provided policy on Abuse Prevention - Identifying Neglect dated [DATE] reflected that Circumstances that can lead to neglect include failure to monitor or supervise residents.</p> <p>The Administrator was notified on [DATE] at 2:50 pm that an Immediate Jeopardy situation had been identified due to above failures.</p> <p>The IJ template for plan of removal was given to the facility on [DATE] at 2:50 pm.</p> <p>The facility's plan of removal was accepted on [DATE] at 11:09 AM. The accepted plan of removal for the Immediate Jeopardy included the following:</p> <p>Plan:</p> <ol style="list-style-type: none"> 1. <p>Identified Resident #1 is no longer at facility .</p> <ol style="list-style-type: none"> 2. <p>Resident #2 is at risk for elopement and has the potential to be affected by the alleged deficient practice. At this time, she is not currently exit seeking as of [DATE].</p> <ol style="list-style-type: none"> 3. <p>The one and only resident deemed an elopement risk has interventions in place that include room next to nurses' station, when she is up in her wheelchair, she is at the nurse's station or in the dining room at mealtimes, any other times she is within eyesight of a staff member. The MDS Coordinator or designee will update the care plan as needed for elopement interventions with a completion of [DATE]. MDS Coordinator will be in-serviced by Administrator to update care plans as needed appropriate with a completion date of [DATE].</p> <ol style="list-style-type: none"> 4. <p>Administrator will in-service and re-educate staff on elopement and abuse and neglect with a follow up posttest starting on [DATE] with a completion on [DATE]. Any remaining staff members will not be allowed back to work until they complete the in-service and posttest.</p> <ol style="list-style-type: none"> 5. <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Elopement drill will be done by DON or designee and will be done on each shift and completed by [DATE]. The DON (upon her return) and the designee who are conducting the elopement drills will be in-serviced by the Administrator regarding the proper procedures of the drill. The elopement drill does list all individuals who are supposed to be notified of an elopement. Any remaining staff will not be allowed back to work until they complete elopement training.</p> <p>6.</p> <p>Administrator has been in-serviced on correct elopement protocol, including notifying the police, by [NAME] President on [DATE].</p> <p>7.</p> <p>Maintenance Manager will buy 10 new screens to put on the rooms completed by [DATE]. On any unoccupied rooms where screens are missing those doors will remain closed as well as the jack and [NAME] bathrooms until the screens can be replaced by [DATE]. All doors will stay closed on any unoccupied rooms as well as the jack and [NAME] bathrooms.</p> <p>8.</p> <p>Maintenance Manager will be in-serviced by Administrator on checking window screen to ensure proper screen placement with a completion date of [DATE].</p> <p>The Survey Team monitored the current plan of removal as follows:</p> <p>Review of the facility's inservice initiated on [DATE] revealed staff were inserviced on elopement and given posttests.</p> <p>Record review of inservice sheet dated [DATE] revealed the Administrator was inserviced on elopement protocols, including notifying the police.</p> <p>Record reviews of elopement drills revealed the Administrator conducted elopement drills on [DATE] at 10:00pm and [DATE] at 10:02 am.</p> <p>Record review of the inservice sheet dated [DATE] revealed the Administrator inserviced the Maintenance Director checking proper screen placement.</p> <p>Observation on [DATE] at 12:00PM revealed all windows had screens. Observation revealed doors for unoccupied resident rooms were closed.</p> <p>Interviews were conducted with staff from 12:00pm-4:30PM on [DATE]. Interview with the Administrator revealed she was inserviced on elopement protocols, including notification of the police. The Administrator stated she conducted elopement drills and inservices on elopement and proper screen placement. Interview with the Maintenance Director revealed the Administrator inserviced him on proper screen placement. The Maintenance Director stated he placed screens on the windows. Interviews with CNA A, CNA B, CNA C, and CNA D, LVN E, LVN F, LVN G, LVN H, LVN K and RN I revealed the staff were inserviced on elopement and safety precautions.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Staff were able to describe elopements, what they would do in the event of a missing resident, and administration was able to describe the system for preventing and handling missing residents and to notify police department in the event of a missing resident.</p> <p>On [DATE] at 4:30 PM, the Administrator were informed the IJ was removed. However, the facility remained out of compliance at a severity of no harm that is not immediate with a scope identified as isolated. The facility needs to ensure in-service training and evaluate the effectiveness of the corrective systems.</p>