

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  02/10/2026
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 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to promptly notify the ordering physician regarding laboratory results outside of clinical reference range for 1 of 3 residents (Resident #1) reviewed for laboratory services. The facility did not ensure the physician was promptly notified when Resident #1's urinalysis results completed on 01/29/26 indicated a urinary tract infection, resulting in a delay in treatment until 02/04/26. This failure could place residents at risk of not receiving lab services as ordered and not providing timely treatment. Findings included: Record review of Resident #1's quarterly MDS assessment, dated 12/11/25, reflected a [AGE] year-old female with an admission date of 09/27/24. Resident #1 had a BIMS score of 15, which indicated she was cognitively intact. She required partial to moderate assistance with activities of daily living, was occasionally incontinent of bladder and frequently incontinent of bowel. Diagnoses included heart failure, dementia and chronic obstructive pulmonary disease (lung diseases that make it hard to breath by restricting air flow). Record review of Resident #1's physician's verbal orders dated 01/27/26, reflected, UA with C&amp;S if indicated one time only. written by LVN C. Record review of Resident #1's Urinalysis lab report completed on 01/29/26, reflected, Urine Nitrates- Positive- (usually indicate a urinary tract infection) .Urine WBC- too many to count (indicate the immune system is fighting infection or inflammation in the urinary tract) . Record review of Resident #1's Physician order summary report dated 02/10/2026 reflected, Macrobid oral capsule 100 mg (antibiotic used to treat uncomplicated urinary tract infections) Give 1 capsule by mouth two times a day for UTI for 10 days.start date 02/04/26. In an interview with Resident #1 on 02/10/26 at 8:30 a.m. she stated she was finally feeling a little better. She stated it took the facility forever to treat her urinary tract infection. She said she told the staff she was having burning on urination and knew she had a urinary tract infection. She stated LVN C brought her a specimen cup, but stated she could not remember the exact date. She stated after they took the specimen it took 5-6 days to get any medication. She stated the urinary burning had stopped. She stated she was still taking the medication the doctor ordered for her. In an interview with LVN A on 02/10/26 at 2:20 p.m. she stated she was the primary charge nurse on the 6 a.m. to 2 p.m. shift. She stated the process they had in place when labs were ordered was they place it on the 24-hour report for follow up. She stated when they received the lab results they review it and either text the MD with the results or faxed it to the physician's office. She stated she notified the physician on 02/03/26 by text message. She stated she was not sure why the MD was not notified sooner. She stated that was the week of the ice storm and stated the MD's office was closed during that time. In an interview with LVN B on 02/10/26 at 2:35 p.m. she stated she worked the 10 p.m. to 6 a.m. shift. She stated any time they have outstanding labs she checks the electronic record to see if the lab results have been uploaded. She stated if they had been uploaded, she prints off the results and places them in the physician's binder for the day shift to call the MD with results. She stated</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  455563	Facility ID:  455563  If continuation sheet Page 1 of 2

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>she was pretty sure she had printed off the lab report for Resident #1 on 01/29/26. She stated she was not sure why the MD was not notified the next day. In an interview with LVN C on 02/10/26 at 2:45 p.m. she stated had worked from 10 p.m. to 6 a.m. on the weekend of 01/31/26. She stated she stayed at the facility that weekend due to the icy weather. She stated she saw Resident #1's lab results and stated there was nothing in the progress notes or on the 24-hour report indicating the MD had been notified. She stated she faxed the lab results to his office. She stated she placed the lab results back in physician's review book. In an interview with Resident #1's MD on 02/10/26 at 3:35 p.m. he stated his expectation for the facility staff was to contact him by phone for any abnormal lab results. He stated he could not recall getting a call from the facility. He stated the concern for not getting notified could result in a delay in treatment. He stated he did not feel the delay caused a significant problem and stated they had started Resident #1 on an antibiotic. During an interview on 02/10/26 at 4:30 p.m., the DON stated she expected the charge nurse who received the lab results to notify the physician in a timely manner of all abnormal labs. She stated they needed to document the notification in the progress notes, so the oncoming staff were aware the notification had been made and note any new orders if any were given. The DON stated she thought the physician was reviewing the labs through the electronic medical records but stated she was not 100% sure if he or his Nurse Practitioner had remote access. She stated she was going to have to set up a better process to monitor labs and ensure they were following up and notifying the MD. She stated she had already started in-servicing the nurses on the protocol and expectations. She stated a delay in treatment for any infection could result in a more severe infection which could require an unnecessary hospitalization. During an interview on 02/10/26 at 4:45 p.m., the Administrator stated he expected the physician to be notified in a timely manner of labs. The Administrator stated the DON was responsible for overseeing and monitoring labs. Record review of the facility's undated policy titled Lab and Diagnostic Test Results-Clinical Protocol reflected, . When test results are reported to the facility, a nurse will first review the results.A nurse will identify the urgency of communicating with the Attending Physician based on physician request, the seriousness of any abnormality, and the individual's current condition.A physician can be notified by phone, fax.another person acting as the physician's agent.Facility staff should document information about when, how, and to whom the information was provided and the response. This should be done in the Progress notes section of the medical record and not on the lab results report.Direct voice communication with the physician is the preferred means for presenting any results requiring immediate notification.</p>		