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	04/29/2026

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 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** Based on interview and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet the resident's medical, nursing, and mental and psychosocial needs for 1 of 5 residents (Resident #1) reviewed for care plans in that:The facility failed to include interventions for ADLs in Resident #1's care plan.This failure could affect residents by placing them at risk of not receiving individualized care and services to meet their needs.Record review of Resident #1's face sheet dated 04/28/2026 revealed a [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses of Unspecified Sequelae of Cerebral Infarction (unspecified neurological deficits or functional impairments remaining after a stroke), Flaccid Hemiplegia Affecting Left Dominant Side (sudden, complete paralysis and loss of muscle tone on the left side), Other Cerebral Infarction (disrupted blood flow to the brain), Paraplegia (paralysis affecting the lower half of the body) and Epilepsy (a brain condition that causes recurring seizures). Record review of Resident #1's quarterly MDS assessment, dated 03/30/2026, reflected a BIMS score of 13, which indicated intact cognitive response. Section GG0130-Functional Abilities revealed substantial/maximal assistance for lower body dressing and putting on/taking off footwear, partial/moderate assistance for upper body dressing, shower/bathe self, and toileting hygiene. Section GG0130 also revealed Resident #1 required set up or clean-up assistance for oral hygiene and eating, and supervision for personal hygiene.Record review of Resident #1's Comprehensive Care Plan reviewed 04/28/2026 failed to address ADLs as a focus of care.During an interview on 04/28/26 at 3:05 p.m., the MDS Coordinator stated MDS was responsible for care plans. She stated ADLs were not included in Resident #1's care plan because she worked remotely and had internet issues. She stated Resident #1's care plan should have been updated after the MDS assessment March 30, 2026. She stated all ADLS's included in the MDS assessment, such as dressing, bathing, toileting, and hygiene, should have been included in the care plan. She stated ADLs included in the care plan were important for the quality of care for residents.During an interview on 04/29/26 at 11:33 a.m., the Corporate Social Worker stated IDT, comprised of nursing, dietary, the therapy director, the MDS Coordinator and Social Worker, met weekly. She stated MDS, considered a part of nursing, was responsible for the implementation of the care plan. She stated ADLs were important to guide staff on what the residents' care needs were. She stated she didn't know why Resident #1's care plan lacked ADL goals and interventions.During an interview on 04/28/26 at 2:34 p.m., the Administrator stated the MDS Coordinator and DON were responsible for the care plan. He stated ADLs, such as hygiene and showers, were important in the care plan because staff needed to know what to do to care for residents and to ensure residents received the care needed. He stated CNAs were hindered without ADLs in the care plan and when the nurse informed them what each resident required.During an interview on 04/29/26 at 10:12 a.m., CNA A stated she was unaware of ADL care, goals, and interventions contained in Resident #1's care plan. She stated she doesn't have access to the POC system that contained it. She stated she figured out Resident #1's ADL care related to hygiene, showers, and incontinent care and Resident #1 told her (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	how the care was done.During an interview on 04/29/26 at 10:38 a.m., CNA B stated she wasn't aware of ADL care plan goals and interventions for Resident #1 since she didn't have access to POC, but she asked the charge nurse. She stated that ADLs in the care plan were important to know what duties were performed and what residents could/could not do. Review of the facility policy titled Comprehensive Care Plans, revised 09/04/24, revealed on page 1, The comprehensive care plan will describe, at a minimum, the following: the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 6 residents (Resident #1) reviewed for personal hygiene.The facility failed to provide Resident #1 with scheduled showers between 03/24/2026 and 04/28/2026.This failure could place residents who require assistance from staff for personal hygiene at risk of not receiving care and services contributing to overall poor hygiene, risk of experiencing a diminished quality of life, and possible skin infections.Record review of Resident #1's face sheet, dated 04/28/2026, revealed a [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses of Unspecified Sequelae of Cerebral Infarction (unspecified neurological deficits or functional impairments remaining after a stroke), Flaccid Hemiplegia Affecting Left Dominant Side (sudden, complete paralysis and loss of muscle tone on the left side), Other Cerebral Infarction (disrupted blood flow to the brain), Paraplegia (paralysis affecting the lower half of the body) and Epilepsy (a brain condition that causes recurring seizures). Record review of Resident #1's quarterly MDS assessment, dated 03/30/2026, reflected a BIMS score of 13, which indicated intact cognitive response. Section GG0130-Functional Abilities revealed partial/moderate assistance (helper does less than half the effort) for showering/bathing.Record review of Resident #1's Comprehensive Care Plan reviewed 04/28/2026 failed to address ADLs as a focus of care.Record review of Resident #1's tasks in the electronic health record did not reflect the residents assigned shower days. Further review of the posted Resident Shower Sheet revealed Resident #1's scheduled shower days were Tuesday, Thursday, Saturday from 6am-6pm.Record review of completed shower sheets revealed Resident #1 was showered 03/28/2026, 04/14/2026, and 04/22/2026.During an interview on 04/28/2026 at 1:08 p.m., Resident #1 revealed she was showered three-four times since arriving at the facility. Resident #1 stated she couldn't remember the last shower. Resident #1 stated she had an odor and could smell herself. Resident #1 was observed neatly dressed; an odor was not observed.During an interview on 04/28/26 at 12:16 p.m., the Administrator revealed the expectation was for residents to shower when they wanted or on their scheduled shower days. The Administrator stated showers and refusals were documented on shower sheets since there wasn't access to the POC system. He stated nurses were responsible for checking daily to ensure residents were showered. He stated showers were important for hygiene and resident rights.During an interview on 04/29/26 at 10:12 a.m., CNA A stated Resident #1 was showered or received bed baths, but she didn't remember when. She stated she failed to document the shower sheets. She stated she didn't have access to the electronic medical record system for documenting ADL care for showers. She stated the risk of unbathed residents included hygiene or skin issues.During an interview on 04/29/26 at 10:38 a.m., CNA B stated she showered Resident #1 once since her admission. She stated CNA A normally showered Resident #1. She stated showers, refusals, and bed baths were documented on the shower sheets. She stated she didn't have POC access for documentation of ADL care. She stated residents were at risk for skin breakdown, smells, odors, and uncleanliness when unbathed.During an interview on 04/29/26 at 1:56 p.m., LVN A stated charge nurses were responsible for overseeing CNAs to ensure residents were showered by checking with the CNA and residents. She said she was too busy with her assigned duties to check if/when residents were showered. She stated shower sheets were kept in the shower sheet book and documented in the POC computer system. She stated showers/bathing were important for hygiene, it helped residents feel better, and it helped residents' skin.Record review of facility policy, dated reviewed 02/11/22, titled, Resident Showers, reflected, Residents will be provided showers as per request or as per shower schedule.