

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455806	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER The Terrace at Denison		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 Memorial Dr Denison, TX 75020	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of needs and preferences for 1 (Resident #1) of 12 residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #1's room was in a position accessible to the resident on 12/02/2025. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings included: Record review of Resident #1's Face Sheet, dated 12/03/2025, reflected the resident was an [AGE] year-old male who admitted on [DATE]. Resident #1 had diagnoses of atherosclerotic heart disease (disease that affects arteries supplying blood to the heart muscle) and diabetes mellitus (the body does not use insulin properly which leads to elevated blood glucose levels). Resident #1 received hospice care services. Record review of Resident #1's Quarterly MDS (tool used to measure health status) Assessment, dated 09/15/2025, reflected severely impaired cognition with a BIMS (tool used to measure cognitive status) score of 00. Section GG (Functional Abilities) indicated Resident #1 was dependent on staff for self-care and mobility needs. Record review of Resident #1's Comprehensive Care Plan, dated 10/04/2025, reflected history of falling related to immobility, chronic pain, incontinence, and decreased cognition. One intervention was to keep call light in reach at all times. During an observation on 12/2/25 at 9:43 AM, Resident #1 was lying in bed asleep. The call light was hanging behind the nightstand and not within the resident's reach. During an observation and interview on 12/02/2025 at 9:59 AM, LVN B entered Resident #1's room. She clipped the call light on Resident #1's bed within his reach. She stated it was important for staff to ensure the call light was in reach when rounding in case the resident needed to call staff. She stated Resident #1's call light was in reach earlier when she gave his medication. During an interview on 12/02/2025 at 2:09 PM, CNA C stated Resident #1's call light should have been within reach. She stated it was important for all residents to be able to let staff know if they needed something. During an interview on 12/03/2025 at 11:59 AM, the Administrator stated Resident #1's call light should have been within reach. He stated staff would not know when the residents needed something if they did not have access to their call lights. He stated call light should always be within reach. During an interview on 12/03/2025 at 1:36 PM, the DON stated Resident 1's call light should have been within reach. She stated the expectation was for all residents' call lights to be in reach whether they were in their bed or sitting in their wheelchair. She stated it was important for the safety of the residents. During an interview on 12/03/2025 at 1:57, the ADON stated the call light should have been within Resident #1's reach. She stated it should be on everyone's mind to monitor residents' call lights. She stated a resident might need something and not be able to reach anyone. She stated it was important for their comfort and to help residents feel safe knowing they could reach someone. Record review of the facility's policy Call System, Residents, updated January 2025, reflected Each resident is provided with a means to call staff directly for assistance form his/her bed, from toileting/bathing facilities and from the floor.</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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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 2 (Resident #2 and Resident #3) of 10 residents reviewed for respiratory care. The facility failed to ensure Resident #2's oxygen tubing (flexible tube used to deliver oxygen to the nose through two prongs) was properly stored when not in use on 12/02/2025. The facility failed to ensure Resident #3's oxygen tubing was properly stored when not in use on 12/02/2025. These failures could place residents at risk for respiratory infection and not having their respiratory needs met. Findings included: Resident #2 Record review of Resident #2's Face Sheet, dated 12/03/2025, reflected a [AGE] year-old female who admitted on [DATE]. The resident had diagnoses which included COPD (lung condition that makes it difficult to breathe) and end stage renal disease (the kidneys do not function). Record review of Resident #2's Quarterly MDS Assessment, dated 09/11/2025, reflected the resident was cognitively intact with a BIMS score of 14. Section O (Special Treatments, Procedures, and Programs) reflected Resident #2 received oxygen therapy. Record review of Resident #2's Comprehensive Care Plan, dated 10/24/2025, reflected a risk for respiratory distress related to diagnoses of asthma (airway narrows and can make breathing difficult) and COPD. One intervention was to keep the oxygen cannula, mask, and tubing bagged when not in use. Record review of Resident #2's Physician Order, dated 11/17/2025, reflected Oxygen at 3 LPM per nasal cannula every shift. An observation and interview on 12/02/2025 at 9:26 AM, revealed Resident #2 sitting up in bed. Resident #2 was receiving oxygen via oxygen tubing connected to an oxygen concentrator. Resident #2's wheelchair was near the bed and had a portable oxygen tank on the back. Oxygen tubing was connected to the portable oxygen tank and looped around the handle of the wheelchair. The oxygen tubing was not in a bag. Resident #2 stated it was usually in a bag. During an observation and interview on 12/02/2025 at 10:05 AM, LVN A entered Resident #2's room and stated the oxygen tubing on the wheelchair should have been stored in a bag. She stated she would replace the oxygen tubing and ensure it was stored in a bag. She stated it was important for infection control. Resident #3 Record review of Resident #3's Face Sheet, dated 12/03/2025, reflected an [AGE] year-old male who admitted on [DATE]. Resident #3 had diagnoses which included COPD (lung condition that makes it difficult to breathe) and diabetes (the body does not use insulin effectively and causes blood sugar levels to rise). Record review of Resident #3's Quarterly MDS Assessment, dated 11/16/2025, reflected the resident had severely impaired cognition with a BIMS score of 05. Section O (special treatments, procedures, and programs) indicated Resident #3 received oxygen therapy. Record review of Resident #3's Baseline Care Plan, dated 11/26/2025, reflected the resident received oxygen therapy while a resident. During an observation and interview on 12/02/2025 at 10:20 AM, Resident #3 was sitting in the wheelchair in his room. The resident was receiving oxygen via a nasal cannula connected to an oxygen cannister on the back of his wheelchair. An oxygen concentrator was on the floor behind the wheelchair. Oxygen tubing was connected to the concentrator and draped over the top of the concentrator. The oxygen tubing was not bagged. An interview was attempted but the resident was unable to answer questions appropriately due to his cognitive status. During an interview on 12/02/2025 at 10:26 AM, LVN A entered Resident #3's room and stated the oxygen tubing should have been in a bag. She stated she would replace the tubing and place it in a bag. LVN A stated it was important to keep the tubing covered because it collected bacteria which could cause respiratory problems for the resident. During an interview on 12/03/2025 at 11:59 AM, the Administrator stated the oxygen tubing should have been stored in bags when not in use. He stated it was important for infection control. He stated staff were provided in-service training. During an interview on 12/03/2025 at 1:36 PM, the DON stated the expectation was for all respiratory items to be stored in a bag when not in use. She stated staff were re-educated to monitor for placement of respiratory tubing when rounding. She stated it was important for infection control. She stated it was an important measure to help prevent upper respiratory infections. During an interview on 12/03/2025 at 1:57 PM, the ADON stated respiratory items should be bagged when not in use. She stated it was important for staff to keep respiratory items as clean as possible to prevent infection because they did not know what was in the air. Review of the facility's policy Oxygen Administration, revised October 2010, reflected Oxygen/nebulizer tubing/masks to be changed by nursing department weekly and documented in the electronic health record. The policy did not reflect storage of</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** Based on observations, interviews, and record review, the facility failed to ensure the medication was stored properly in locked compartments or provided a safe and secured storage with limited access for 1 (Resident #4) of 8 residents reviewed for medication storage. The facility failed to ensure a bottle of Milk of Magnesia (liquid medication used to treat constipation) was not on the nightstand next to Resident #4's bed on 12/03/2025. This failure could place the residents at risk of accidental overdose or misuse of medication. Findings included: Record review of Resident #4's Face Sheet, dated 12/03/2025, reflected an [AGE] year-old female who admitted on [DATE]. The resident had diagnoses which included osteoarthritis (joint pain and stiffness) and repeated falls. Record review of Resident #4's Quarterly MDS Assessment, dated 09/21/2025, reflected the resident was cognitively intact with a BIMS score of 13. Record review of Resident #4's Comprehensive Care Plan, dated 09/27/2025, did not reflect the resident self-administered her medication. Record review of Resident #4's Physician's Orders did not reflect an order for Milk of Magnesia or for the resident to self-administer medication. During an observation and interview on 12/03/2025 at 9:06 AM, Resident #4 was lying in bed awake. A bottle of Milk of Magnesia was observed on the nightstand next to the bed. Resident #4 stated she did not use it very often but had it in case she needed it. In an interview on 12/03/2025 at 9:32 AM, LVN A stated the bottle of Milk of Magnesia should not have been at the bedside in Resident #4's room. LVN A stated Resident #4 might take too much of the medicine. She stated another resident might take it that had an allergy to the medication or overdose. She went to the resident's room and asked her about the medication. Resident #4 stated that a family member brought the bottle of medicine. Resident #4 stated she had rubbed a little in her mouth when she had a place that bothered her, and it helped. LVN A explained medication could not be left in her room and removed it. In an interview on 12/03/2025 at 1:20 PM, the DON stated the resident's family brought the medication to Resident #4 but did not make anyone aware. She stated the medication was removed from Resident #4's room and the resident was educated on why the medication could not be left in the room. She stated unless an assessment to self-administer medication was completed and approved by the physician, a resident could not have medication at the bedside. She stated it was also a safety concern for other residents who wandered by and saw it. The DON stated the social worker contacted the family to ensure they did not bring medication to the resident. In an interview on 11/18/2025 at 1:57 PM, the ADON stated the medication should not have been in Resident #4's room. She stated the resident might take too much. She stated it was important for staff to monitor any medication the resident took. Record review of the facility's policy Self-Administration of Medication, revised February 2021, reflected Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.</p>		