STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455806	A. Building B. Wing	05/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terrace at Denison	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview, and record review, the facility failed to protect the resident's right to be free from neglect when (Resident #1) was not provided with goods and services to avoid harm when LVN C observed previous shift had not started feeding pump that required scheduled enteral feeding of food and water for 1 of 2 residents requiring tube feedings. -The facility failed to ensure one (Resident #1) of two residents, received required enteral food and hydration according to physician orders. This failure placed two of two residents requiring enteral food and hydration administration due to inability to orally swallow fluids, at risk of being dehydrated.Findings include: Record review of Resident #1's face sheet dated 05/02/2026, reflected the resident was a [AGE] year old male admitted to the facility on [DATE]. Resident #1 had DX which included: nontraumatic intracerebral hemorrhage (stroke), encephalopathy (overall brain dysfunction), hypertension (high blood pressure), congestive heart failure (heart cannot pump blood effectively leading to fluid buildup), and acute respiratory failure (lungs cannot provide enough oxygen to the blood). Record review of Resident #1's admission MDS assessment dated [DATE], reflected he had a BIMS score of 99 indicating the resident was unable to complete the interview. The MDS assessment under Section C - Cognitive Patterns reflected his ability to make decisions regarding tasks of daily life was severely impaired. Further review of the MDS assessment under Section GG - Functional Abilities, reflected Resident #1 required supervision and was dependent on staff for all ADLs. Record review of Resident #1's care plan dated 03/19/2026, reflected that the resident had no current plan for discharge and will remain in the facility as permanent residence. The resident was full code status with interventions to ensure staff were aware of Resident #1's advance planning decisions. The resident had a communication problem with interventions to anticipate and meet needs. The resident had impaired cognitive function or impaired thought processes with interventions to administer medications as ordered and keep the resident's routine consistent and try to provide consistent care givers as much as possible to decrease confusion.Record review of Resident #1's consolidated physician orders dated 04/24/2026, reflected the following:Jevity 1.5 at 50 ML/HR for 22 hours plus water flushes at 50 ML/HR via feeding pump.Pump down for 2 hours for ADLs on the day shift.Change enteral bag every 24 hours.Allergies were Alprazolam, diazepam, Levaquin, Avocado, Banana, Strawberry, Tape. Record review for Resident #1's initial nutritional assessment by a Registered Dietitian was not found in the EMR. Standards of Care reflected that a Registered Dietitian must collaborate with the physician to calculate calories, fluid needs, protein and all components of nutrition and hydration for residents requiring enteral feeding due to inability to swallow oral food and fluids and take oral medications. Record review on 05/02/2026 of Resident #1's weight record reflected current weight history was not found in the EMR. Standards of Care per Lippincott Nursing manual reflected upon admission to a Long-Term Care facility; residents are weighed weekly for four weeks then monthly and as needed to establish a baseline weight measurement for ongoing weight gain or weight loss monitoring. In an observation on 05/02/2026 at 10:00 AM, Resident #1 was in his bed. He could not participate in conversation due to mental status. His enteral feeding and water bags were noted to be completely (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	empty with tubing connected to the resident. Resident #1 was also noted to be on EBP for infection control purposes. In an interview on 05/02/2026 at 10:30 AM with LVN C who stated she worked every weekend. She stated she was the charge nurse for Resident #1 and would come get this surveyor when it was time to administer enteral medications for Resident #1. In an observation on 05/02/2026 at 11:29 AM with LVN C, upon entry to Resident #1's room, LVN C did not wash her hands or dress in PPE as required for EBP. She did not knock before entering the resident's room, did not speak to Resident #1 or explain what service was going to be provided. Jevity 1.5 at 50 ML/HR and water bag for free flow water administration continued to be empty with the feeding pump turned to the off position. Feeding tube observed to have formula in the tubing and was connected to the resident's gastric port. On a bedside table next to Resident #1's bed, several medications were noted to be crushed and in un-labeled clear medicine cups with clear liquid. LVN C did not wash her hands. She had long artificial nails on fingertips of both hands. LVN C said she could not remember what medication was in each cup because she preset them prior to notifying the surveyor it was time to administer the medications. Other medication cups were observed to be on the bedside table with clear liquid in each cup she identified as water. She could not recall the facility Enhanced Barrier Precautions policy or procedure required for Resident #1. LVN C was stopped and asked to discard all medications and start over. Her laptop with the MAR was left in the resident's room. She did not wash her hands after discarding the pre-set medications. She went to the medication cart to start the process over. LVN C checked Resident #1's medications against the MAR, removed individual doses from blister packaged medication cards, placed the medication in clear bags, crushed each medication individually and placed them in labeled medication cups. LVN C took the medication cups into the resident's room and placed them on the bedside table. LVN C did not put on PPE that was required for enhanced barrier precautions for Resident #1 while providing care. LVN C disconnected the feeding tube from Resident #1's gastric port and draped the tube over the feeding pump pole without capping the end of the tube. The end of the tube touched the surface of the feeding pump machine pole holding the empty Jevity and water bags. LVN C opened the packaged 60 cc syringe, pulled 20 ccs of air into the syringe, connected the end of the syringe into the gastric port, placed her stethoscope over the stomach area and pushed the air and listened for tube placement. She checked for stomach content residual by pulling back on the plunger of the 60 cc syringe. There was no residual feeding formula or water observed in the syringe. LVN C did not change her gloves before administering the enteral medications. LVN C did not add extra water to completely administer each medication dose. Residual medication was noted in each cup indicating in the full dose of medication was not administered. A 10cc water flush was given after each individual medication. At the end of all medication administration LVN C reconnected the feeding tube with the contaminated tube tip back into the resident's gastric port. There was no Jevity 1.5 or intermittent water flush hung at that time to administer to the resident per physician orders. In an interview on 05/02/2026 at 12:00 PM with LVN C about the empty Jevity 1.5 and water bags. She said RN B workedthe 10 PM to 6 AM shift and was supposed to hang a new Jevity 1.5 formula bag and water flush bag before leaving theshift at 6:00 AM; but she left without completing the task. LVN C said after discovering the Jevity 1.5 and water flushes were not started by the off going nurse, that she (LVN C)should have started feeding and water when she began the 6 AM to 2 PM shift but she did not. She said this caused Resident #1 who was totally dependent on staff for all ADLs to be without nourishment and water for approximately six hours andher inaction would be considered neglect of Resident #1. Administering enteral medications, enteral feedings and water by a feeding pump was within LVN C's scope of practice according to the Texas Board of Nursing Rule 217.11 Standards of Nursing Practice. LVN C was unable to determine what the residents' nutritional and hydration needs were. She could not say how to ensure the residents' nutritional and hydration needs were met. She could not determine whether the tube feeding was adequate to maintain acceptable nutrition and hydration parameters. Standards of Nursing Practice reflect all unclear orders must be clarified by the physician. Interview on 05/02/2026 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 12:30 PM with ADON reflected RN B was the nurse on duty on 05/02/2026 for the 10:00 PM to 6:00 AM shift. A phone number was provided for RN B with no response to the call on 05/02/2026 at 12:40 PM and again at 2:45 PM. In a brief telephone interview on 05/03/2026 at 10:45 AM with the facility medical director, he stated he was aware the tube feeding was down for Resident #1 for multiple hours on 05/03/2026; however, he was unable to say what staff notified him or give the time of the notification or any details to be followed up by interview, observation, or record review. Interview on 05/03/2026 at 11:00 AM with CNA D who worked every weekend for about six months. She said an example of resident neglect would be not feeding the residents, answering call lights, or bathing and other basic care needs. Interview on 05/03/2026 at 11:32 AM with LVN E who has worked here for three years He said not following physician orders like providing food and fluids to residents would be considered neglectful. Interview on 05/03/2026 at 11:48 AM CNA F who worked on the memory unit. She's worked in this building for 32 years. She said not feeding or providing fluids for all residents would be considered neglectful Interview on 05/03/2026 at 11:57 AM with CNA G who worked weekends said if the facility failed to feed or hydrate residents, would be neglectful as well as not providing other care to resident dependent on nursing staff for all ADLs. Interview on 05/03/2026 at 12:15 PM with CNA H who had worked here for one year stated not giving food and hydration to any resident was neglectful. Interviews on 05/03/2026 at 12:49 PM revealed the Administrator and DON strongly agreed that failure by nursing staff to provide food and hydration to a resident totally dependent on staff for all ADLS per physician orders was considered neglectful. Record review on 05/02/2026 of undated ANE policy reflected in part the following; Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Develop and implement policies and protocols to prevent and identify: abuse or mistreatment of residents; neglect of residents; and/or theft, exploitation or misappropriation of resident property. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems. Implement measures to address factors that may lead to abusive situations, for example: adequately prepare staff for caregiving responsibilities; provide staff with opportunities to express challenges related to their job and work environment without reprimand or retaliation; instruct staff regarding appropriate ways to address interpersonal conflicts; and help staff understand how cultural, religious and ethnic differences can lead to misunderstanding and conflicts. Establish and implement a QAPI review and analysis of reports, allegations or findings of abuse, neglect mistreatment or misappropriation of property. Record review on 05/02/2026 of undated Enteral Feeding Policy reflected in part the following: The interdisciplinary team, including the Dietitian, will conduct a full nutritional assessment within current initial assessment timeframes to determine the clinical necessity of enteral feedings. The assessment will include:Evaluation of the resident's current nutritional status;Evaluation of the resident's current clinical status;Relevant functional and psychosocial factors; andA review of interventions to maintain oral intake prior to the use of a feeding tube and the resident's response to them. The recommendation to initiate the use of a feeding will be based on the results of the comprehensive nutritional assessment, and will be consistent with current standards of practice, the resident's advance directives, treatment goals and facility policies. Enteral nutrition will be ordered by the Physician based on the recommendations of the Dietitian. If a feeding tube isordered, the Physician and interdisciplinary team will document why enteral nutrition is medically necessary. The decision to continue or discontinue the use of the feeding tube will be made through collaboration between the interdisciplinary team, the Physician and the resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (Resident #1, Resident #2) of five residents reviewed for infection control. -The facility failed to ensure Resident #1 and Resident #2, who were on Enhanced Barrier Precautions, were protected as evidenced by nursing staff not wearing personal protective equipment during care. This failure placed all residents at risk for the spread of infections and decreased quality of life.Findings include: Record review of Resident #1's face sheet dated 05/02/2026, reflected the resident was a [AGE] year old male admitted to the facility on [DATE]. Resident #1 had DX which included: nontraumatic intracerebral hemorrhage (stroke), encephalopathy (overall brain dysfunction), hypertension (high blood pressure), congestive heart failure (heart cannot pump blood effectively leading to fluid buildup), and acute respiratory failure (lungs cannot provide enough oxygen to the blood). Record review of Resident #1's admission MDS assessment dated [DATE], reflected he had a BIMS score of 99 indicating the resident was unable to complete the interview. The MDS assessment under Section C - Cognitive Patterns reflected his ability to make decisions regarding tasks of daily life was severely impaired. Further review of the MDS assessment under Section GG - Functional Abilities, reflected Resident #1 required supervision and was dependent on staff for all ADLs. Record review of Resident #1's care plan dated 03/19/2026, reflected that the resident had no current plan for discharge and will remain in the facility as permanent residence. The resident was full code status with interventions to ensure staff were aware of Resident #1's advance care planning decisions. The resident had a communication problem with interventions to anticipate and meet needs. The resident had impaired cognitive function or impaired thought processes with interventions to administer medications as ordered and keep the resident's routine consistent and try to provide consistent care givers as much as possible to decrease confusion. In an observation on 05/02/2026 at 11:29 AM with LVN C, upon entry to Resident #1's room, LVN C did not wash her hands or dress in PPE as required for EBP. An observation on 05/02/2025 at 11:29 AM on a bedside table next to Resident #1's bed, several medications were noted to be crushed and in un-labeled, clear medicine cups with clear liquid. LVN C did not wash her hands. She had long artificial nails on fingertips of both hands. She could not recall the facility Enhanced Barrier Precautions policy or procedure for a resident on EBP. LVN C disconnected the feeding tube from Resident #1's gastric port and draped the tube over the feeding pump pole without capping the end of the tube. The end of the tube touched the surface of the feeding pump machine pole holding the empty Jevity and water bags contaminating the tip of the feeding tube that connected to Resident #1's gastric port. LVN C did not change her gloves before adding clear liquid from a previously opened, undated, 64 ounce bottle into a four ounce plastic water cup. LVN C did now wash her hands after providing care for Resident #1. An interview on 05/02/2026 at 12:05 PM with Resident #1's family member, who arrived during the medication administration pass reflected this was her first time to visit this facility and Resident #1 since he was admitted . She said she had no information to share for the interview. She said she was not aware of EBP and was not told by facility staff she needed to gown and glove prior to entering Resident #1's room for infection control purposes. Record review of Resident's #2's face sheet dated 03/18/2026, reflected a [AGE] year old female admitted to this facility on 01/21/2026 with the following DX: Right leg fracture, pressure injury to the right heel and pressure injury to the left heel, urinary tract infection, metabolic encephalopathy (overall brain dysfunction), anxiety disorder, dementia, and major depressive disorder. Record review of Resident #2's admission MDS assessment dated [DATE] reflected under Section C - Cognitive Patterns she had a BIMS score of 03 which indicated she was severely cognitively impaired. Under MDS Section GG - Functional Abilities reflected she required moderate supervision (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and moderate assistance with all ADLs. She required a wheelchair for mobility. Under Section K - Bowel and Bladder reflected she was incontinent of both. Under Section K - Swallowing and Nutritional Status reflected she was admitted with an established gastric tube status. Under MDS Section M - Skin Conditions reflected she was admitted with two pressure injuries to the right and left heels. Record review of Resident #2's care plan dated 01/27/2026 reflected the resident required EBP; interventions reflected in part the following interventions: Staff must use gown and gloves during high-contact resident care activities that could possibly result in transfer of MDROs to hands and clothing or staff. Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a MDRO as well as those who are not confirmed to have an MDRO (e.g., residents with wounds or indwelling medical devices). Gowns will be available outside of room or in room for staff to don when performing direct care with resident. Sign for EBP will be outside resident's room to alert staff of precautions with direct care procedures. Staff are to wash hands with soap and water, or use alcohol based gel when entering and exiting the resident room. Staff will take trash bag into room for disposing of gown, tie bag, and carry to trash receptacle. Record review of Resident #2's skin/wound treatment sheet dated 04/29/2026 reflected three different pressure injuries as follows: Injury #1 was identified as unstageable pressure injury to the right heel; 1.8 cm by 1.5 cm by 0.1 cm. Treatment order read to cleanse with wound cleanser apply Iodosorb Gel and bordered dressing daily. Nurse documented to be improving without complications. Injury #2 was identified as stage three pressure injury to left heel 0.6 cm by 0.5 cm by 0.1 cm. Treatment order read to cleanse with wound cleanser, apply Betadine and leave open to air daily. Nurse documented to be healing without complications. Injury #3 was identified as a stage two pressure injury to the Sacrum; 2.0 cm by 2.0 cm by 0 cm documented as new and acquired in house on 04/29/2026. Treatment order to cleanse with wound cleanser, apply Hydrocolloid dressing, leave open to air three times per week and PRN. Nurse documented to be healing without complications. In an interview on 05/03/2026 at 1:32 PM with RN J reflected the facility had a wound care vendor that came weekly on Wednesday and provided assessments, wound care, clinical documentation updates, and wound orders. RN J said she worked here on weekends. In an observation on 05/03/2026 at 1:45 PM, RN J gathered wound care supplies and carried them into Resident #2's room and placed them on a clean bedside table. A red bag was opened for trash and placed on the resident's bed. Resident #2 was noted to be on EBP as evidenced by a sign outside her door and PPE available. She was observed lying in bed after receiving personal care for an incontinence episode by CNA K and CNA L, who was observed to not have on PPE prior to entering Resident #2's room. RN J was observed not washing her hands or putting on PPE for EBP before entering Resident #2's room. RN J entered the residents' room, explained what she was going to do, put on clean gloves and performed wound care to left heel. RN J changed gloves without hand hygiene and performed wound care to the right heel. RN changed gloves without hand hygiene and performed wound care to the wound on the posterior sacrum wound. RN J disposed of trash, took off her gloves, left the resident's room without washing her hands. Interview on 05/03/2026 at 11:00 AM with CNA D who worked every weekend for about six months. She said there had not been an in-service on EBP recently, and she could not remember what the EBP policy and procedure covered. She was not aware of which residents require the use of PPE prior to providing high-contact care activities. She could not give an example of a multi-drug resistant organism associated with EBP. Interview on 05/03/2026 at 11:32 AM with LVN E who has worked here for three years. He said there was enough PPE to protect himself and residents but an in-service on EBP has not been given recently. He could not say what EBP policy and procedure covered. He could not name an example of a multi-drug resistant organism associated with EBP. He was not aware of which residents require the use of PPE prior to providing high-contact care activities. Interview on 05/03/2026 at 12:07 PM with the housekeeping supervisor who is Spanish speaking only reflected the conversation was conducted through translator app on her phone. She had worked here for two years. She said there is enough PPE to protect herself and the residents but could not explain (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	what the EBP policy and procedure covered. She could not name an example of a multi-drug resistant organism associated with EBP. She was not aware of which residents require the use of PPE prior to providing high-contact care activities such as bathing, dressing, and helping with ADLs. Interview on 05/03/2026 at 12:15 PM with CNA H who had worked here for one year. She said there is enough PPE to protect herself and the residents. She could not remember what the EBP policy and procedure covered and could not remember a recent EBP in-service provided in the last two months. She could not name an example of a multi-drug resistant organism associated with EBP. She was not aware of which residents require the use of PPE prior to providing high-contact care activities like helping with ADLs. Interview with DON on 05/03/2026 at 3:00 PM revealed the ADON was the facility Infection Preventionist. The DON said she (the DON) was the expert staff for training on Enhanced Barrier Precautions. The ADON was not available for interview. Record review of the facility's policy entitled Enhanced Barrier Precautions dated 02/25/2025 reflected in part the following:Policy Statement - Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.Policy Interpretation and Implementation - Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the transmission of multi-drug-resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). Personal protective equipment (PPE) is changed before caring for another resident. Face protection may be used if there is also a risk of splash or spray. Examples of high-contact resident care activities requiring the use of gowns and gloves for EBPs include:DressingBathing/showeringTransferringProviding hygieneChanging linensDevice care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, and wound care or any skin opening requiring a dressing. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. Standard precautions apply to the care of all residents regardless of suspected or confirmed infection or colonization status. Staff are trained prior to caring for residents on EBPs. Signs are posted on the door or wall outside the resident room indicating the type of precautions and PPE required. PPE for EBP's is available outside or inside of the resident rooms. Residents, families and visitors are notified of the implementation of EBPs throughout the facility.