STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675212	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Homestead of Denison	1101 Reba McEntire LN 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 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** 34918 Based on observation, interview, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two of 12 residents (Resident #1 and Resident #2) observed for infection control. 1. The facility failed to ensure that CNA A changed her gloves and performed hand hygiene while providing incontinence care to Resident #1 and transport dirty linens in a plastic bag on 11/05/24. 2. The facility failed to ensure that CNA B changed her gloves and performed hand hygiene while providing incontinence care to Resident #2 and remove her gloves before leaving the room on 11/06/24. These failures could place the residents at risk of cross-contamination and development of infection. Findings included: 1. Record review of Resident #1's Face sheet dated 11/06/24 reflected a [AGE] year-old female with an admitted [DATE]. Her diagnoses included cerebral infarction (disrupted blood flow to the brain), hemiplegia affecting right side (paralysis) and diabetes. Record review of Resident #1's quarterly MDS dated [DATE] reflected the resident had a BIMS of 15 which indicated she was cognitively intact. She required partial to moderate assistance with toileting and was always incontinent of bladder and bowel. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 11/05/24 at 09:40 a.m. revealed CNA A entered Resident #1 and Resident #3's room. CNA A went to Resident #3's unmade bed and proceeded to strip the linens from the bed without gloves on. CNA A stated to Resident #1, she would be back to provide her incontinent care. CNA A wadded up the dirty linens from Resident #3's bed, holding the linens against her uniform and left the room to deposit the linens in the soiled linen barrel. CNA A then went to the clean linen cart and retrieved a package of wipes, a plastic bag and gloves and re-entered Resident #1's room to provide incontinence care. CNA A put on gloves without performing hand hygiene and unfastened the resident's brief and cleaned down each groin, across the pubic area and down the middle. CNA A then went to the closet, wearing her soiled gloves, and retrieved a clean brief. CNA A then assisted the resident onto her side revealing she had a moderate bowel movement. CNA A cleaned the resident from front to back, removed the soiled brief and then reached into her pants pocket and retrieved a tube of barrier cream and applied the barrier cream while still wearing her soiled gloves. CNA A then wiped the excess barrier cream from her gloves onto the clean brief and had the resident roll back onto her back. CNA A then placed the tube of barrier cream back into her pants pocket and then retrieved a bottle of powder from another pocket and sprinkled the powder on the resident's pubic area and groin area. CNA A then fastened the resident's brief and repositioned the resident. CNA A removed her gloves, gathered the trash bag and left the room without performing hand hygiene. In an interview with CNA A on 11/04/24 at 09:50 a.m. she stated she was supposed to place dirty linens in a plastic bag. She stated she was behind this morning and just did not think when she stripped Resident #3's bed. She stated when she carried the linens against her uniform, she had cross contaminated herself. She stated she was supposed to perform hand hygiene before and after care, when her hands were soiled and was supposed to wash her hands after she entered the room and before she left. She stated she had failed to do that. She stated she had provided the tube of barrier cream herself, because she did not care for the small packets of barrier cream the facility had on hand. She stated she had been taking the tube of barrier cream from resident to resident. She stated she realized now how that could cause cross contamination between resident to resident. 2. Record review of Resident #2's Face sheet dated 11/06/24 reflected a [AGE] year-old male with an admitted [DATE]. His diagnoses included hemiplegia affecting left side (paralysis), epilepsy (seizure disorder) and acute cystitis (urinary tract infection that cause inflammation of the bladder). Record review of resident #2's quarterly MDS assessment, dated 09/25/24, reflected a staff assessment of mental status which indicated he was moderately cognitively impaired. He required substantial to maximum assistance for all ADL's and was frequently incontinent of bowel and always incontinent of urine. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 11/06/24 at 09:00 a.m. revealed CNA B entered Resident #2's room to provide incontinence care. CNA B washed her hands and put on gloves and went to the closet and gathered a shirt and pair of pants for the resident. CNA B unfastened the resident's brief and cleaned down each groin, across the pubic area and retracted the foreskin and cleaned the tip of the penis wiped down the shaft and changed the wipes with each pass. CNA B assisted the resident onto his side and cleaned the resident from front to back. CNA B placed a clean brief under the resident without changing her gloves and performing hand hygiene. CNA B repositioned the resident back onto his back and fastened the brief and put on his clean pants and shirt. CNA B then went to the resident's chest of drawers, wearing the soiled gloves, and searched for a pair of socks. CNA B stated she would have to go out of the room to retrieve some socks. CNA B removed her gloves, exited the room, and used the hand sanitizer on the hallway way and retrieved a pair of non-slip socks from the linen cart. CNA B re-entered the room, washed her hands and put on gloves. CNA B placed the socks on the resident and assisted him to the side of the bed and then transferred him from the bed to the wheelchair. CNA B gathered up the trash and bag of soiled linen and left the room, still wearing her gloves, and entered the soiled linen closet at the end of the hall. CNA B deposited the trash and soiled linens and then removed her gloves and performed hand hygiene. In an interview on 11/06/24 at 09:20 p.m. with CNA B she stated she was supposed to wash her hands before and after care and before going from dirty to clean. She stated she realized she had missed a step because she was nervous. She stated she was supposed to remove her gloves before leaving the room and had just forgot. She stated the risk of not changing her gloves and performing hand hygiene placed the resident at risk of infections. She stated gloves were never to be worn after leaving the resident's room, because they were considered contaminated and risked spreading germs. In an interview on 11/06/24 at 01:00 p.m. with DON she stated staff were supposed to wash hands and change gloves before, and after completion of cleaning a resident and after completion of care. She stated staff were never to wear gloves after leaving the resident's room since they were considered contaminated. She stated soiled linens were always to be placed in a plastic bag before removing them from the residents' room. She stated the facility provided individual packets of barrier cream for residents and tubes of barrier cream or powder should not be shared from resident to resident due to the risk of cross contamination and the spread of germs. She stated she had worked so hard with the staff on skills and stated they were all aware of what they were supposed to be doing. She stated the risk of failing to perform hand hygiene was increased infections and cross contamination. Record review of CNA A's competency check off for hand hygiene, infection control and peri-care revealed she was proficient in care as of 07/15/24. Record review of CNA B's competency check off for hand hygiene, infection control and peri-care revealed she was proficient in care as of 11/01/24. Record review of the facility's policy titled, Handwashing/Hand Hygiene, dated December 2022, reflected, The facility considers hand hygiene the primary means to prevent the spread of infections All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection .Wash hands with soap and water .when hands are visibly soiled .Use and alcohol-based hand rub .Before and after direct contact with residents .Before moving from a contaminated body site to a clean body site during resident care .After removing gloves .Hand hygiene is the final step after removing and disposing of personal protective equipment .The use of gloves does not replace hand washing/hand hygiene . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled, Laundry and Bedding, Soiled, dated September 2022, reflected, Soiled laundry/bedding shall be handled, transported and processed according to best practices for infection prevention and control .Contaminated laundry is bagged or contained at the point of collection (i.e., location where it was used) .Contaminated linen and laundry bags are not held close to the body or squeezed during transport .