

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675212	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/03/2025
NAME OF PROVIDER OR SUPPLIER  The Homestead of Denison		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42971</p> <p>Based on interview and record review the facility failed to maintain medical records in accordance with accepted professional standards and practices for one of twenty-four residents (Resident #165) reviewed for medical records.</p> <p>LVN F and RT G failed to document physician notification about the Resident #165's trach dislodgement and change of condition on [DATE].</p> <p>The noncompliance was identified as PNC from [DATE] to [DATE]. The facility had corrected the noncompliance before the survey began on [DATE].</p> <p>This failure placed residents at risk for inaccurate medical records.</p> <p>Findings include:</p> <p>Record review of Resident #165's Comprehensive MDS assessment, dated [DATE], reflected a [AGE] year-old female admitted to the facility on [DATE] and a re-admission on [DATE]. Resident #165 had a BIMS of 15 which indicated her cognition was intact. Resident #165 required partial assistance with ADLs. Her diagnoses included chronic obstructive pulmonary disease (a group of lung diseases that cause ongoing breathing problems), respiratory failure (not enough oxygen in the blood). In Section O-Special Treatments, Procedures, and Programs it reflected she required tracheostomy (surgical procedure which consists of making an incision on the anterior aspect of the neck and opening a direct airway through an incision in the trachea) care and oxygen therapy.</p> <p>Record review of Resident #165's care plan, dated [DATE], reflected, [Resident #165] has a tracheostomy (related to respiratory failure .Goal .The resident will have no signs or symptoms of infection through the review date .Interventions .Ensure that trach ties are secured at all times . Monitor/document for restlessness, agitation, confusion, increased heart rate, and bradycardia (decreased heart rate)</p> <p>Record review of the Order Summary Report dated ,d+[DATE] for Resident #165 indicated orders:</p> <ul style="list-style-type: none"> <li>- change inner cannula daily and as needed, start date of [DATE].</li> <li>- Change trach collar setup as needed, start date of [DATE].</li> </ul> <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
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Change trach tube every 3 month on dayshift and as needed, start date of [DATE].</p> <p>- Cleanse trach site and change dressing every shift and as needed, start date [DATE].</p> <p>- Code status: full code, start date of [DATE].</p> <p>Record review of the nursing progress note dated [DATE] for Resident #165 and completed by LVN F indicated: At 6:30 PM , RT G was in resident's room, resident's tracheostomy tube was not all the way in, it would not advance, RT G removed the tube to reinsert it properly, the trach tube would not advance, Residents O2 was 96%. resident was following commands and looking at nurse. at 6:38 PM resident saturations were decreasing, at 6:40 PM resident became unconscious and pulse was at 50, Pulse declined, and CPR was initiated at 6:40 PM, 911 was called at 6:40 PM. At 6:50 PM EMS has not arrived, recalled 911, Operator said EMT was on the way. 911 dispatched another [NAME] EMS, at 7:00 PM EMS arrived, CPR remained in progress, EMT continued CPR. At 7:13 PM EMS ceased CPR and stated resident was deceased . EMS left facility not removing the body. At 7:17 PM DON was notified, at 7:19 PM family member was notified, at 10:00 family arrived at facility.</p> <p>Record review of the nursing progress note dated [DATE] for Resident #165 and completed by RT G indicated: Around 6:30 PM pt called me in and asked if I could suction her. I tried to pass the suction tube but it would not pass. I checked her trach and found it part way out. I notified the nurse. I also notified RT director. He advised to take trach all the way out and add some lubricant and try to replace trach. Attempted to replace trach twice but could not get to go in. Nurse was holding trach collar trying to get her O2 up higher to try and insert trach again but pt started desatting (a drop I a person's oxygen saturation levels) quickly. I took out her ambu bag and hooked it up to e-tank and started bagging. we bagged pt for 10 minutes trying to get sats up. pt lost consciousness around 6:40 PM so the nurse called 911. CPR was started and we continued to bag pt and administer CPR until EMS arrived. PT lost pulse just as EMS arrived. EMS arrived around 7:00 PM. they took over CPR and placed AED leads on pt. they performed CPR for a few minutes and pronounced her deceased .</p> <p>In an interview with the RT Director on [DATE] at 3:24 PM he stated RT G called him and told him about Resident #165's trach partial dislodgement, he told her to pull the trach all the way-out and to reinsert it properly. He stated the insertion of the trach is part of the school education for respiratory therapists. He stated the RT G tried twice to reinsert the trach and she called 911. That was the expectation.</p> <p>In an interview with the physician on [DATE] at 4:10 PM he stated in general if a trach dislodged, respiratory therapist supposed to reinsert it that is why an extra trach by the bed side. He stated respiratory therapists were trained to replace the trach, if the trach was partially dislodged, they had to pull it to reestablish the air way. He stated the respiratory therapists were capable to replace the trach, it is not common to fail to replace it, but it happens because sometimes the opening of the stoma is not straight. It is unfortunate. He stated if a trach came out, first thing to do was to try to put it back in. It was the respiratory therapist scope of practice to replace the trach. He stated They did what I expected them to do. I am not expecting them to call me during a code. the protocol of the emergency is to call 911. I know from experience the RT change the trach. Is in their scope of practice. If not able to get it back - call 911.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with LVN F on [DATE] at 1:45 PM she stated everything was very fast, when Resident #165 lost consciousness, she started CPR and told another staff to call 911. LVN F stated she called the physician after the code. She stated she forgot to document that she called the physician.</p> <p>Attempted to reach RT G on [DATE] at 1:50 PM by phone. No answer.</p> <p>Interview with LVN E on [DATE] at 1:35 PM she stated that Resident #165 had history of trach dislodgment. She stated on [DATE] Resident #165's trach was dislodged; RT H tried to reinsert it twice unsuccessfully. They called 911, they arrived to the facility and transferred the resident to the hospital. LVN E stated the difference between the two incidents was 911 arrived to the facility in less than 10 min on [DATE] instead of 20 min on [DATE].</p> <p>Attempted to reach RT H on [DATE] at 1:42 PM by phone. No answer.</p> <p>Interview with the DON on [DATE] at 4:42 PM she stated she started working in the facility on [DATE], she stated LVN F called her after the code. She stated she did not expect staff to call her or call the physician during an emergency. She stated per protocol they called 911. The DON stated she expected LVN F to document that she called the physician.</p> <p>Record review of the facility's in-service initiated on [DATE] by the DON reflected 23 of nursing staff were in-serviced on change of condition, notifications, and documentation.</p> <p>Individual interviews with LVNs, RNs from all shifts (LVN D, LVN E, LVN I, LVN J, LVN K, LVN L, and RN M ) on [DATE] and [DATE] revealed they had received in-service training on change of condition, notifications, and documentation.</p> <p>Record review of the facility's policy Emergency Trach Care Procedures, not dated, reflected the following: .If you are unable to re-inset either the same size trach tube or a smaller size, call 911 and have the resident shipped to the ER.</p> <p>Review of the facility's policy Change in a Resident's Condition or Status, revised [DATE], reflected the following: .The nurse will notify the resident's Attending Physician, Nurse Practitioner or physician on call when there has been . significant change in the resident's physical/emotional/mental condition . Need to transfer the resident to a hospital/treatment center .</p>		