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	07/16/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for one of seven residents (Resident #1) reviewed for abuse. The facility failed to protect Resident #1 from physical abuse by CNA A on 03/30/25, which resulted in Resident #1 sustaining a head injury and contusion to her forehead. The noncompliance was identified as Past Noncompliance IJ. The noncompliance began on 03/30/25 at 6:40 p.m. and ended on 03/31/25. The facility had corrected the noncompliance before the incident investigation began on 07/15/2025. This failure could place residents at risk of serious abuse, injury and harm. Findings included: Record review of Resident #1's face sheet, dated 07/15/25, reflected she was a [AGE] year-old female, admitted to the facility on [DATE] with the diagnoses of Alzheimer's and cognitive communication deficit (communication difficulties stemming from impairments in cognitive skills like attention, memory, and problem- solving). Record review of Resident #1's Quarterly comprehensive MDS, dated [DATE], reflected a BIMS of 4, had continuous behaviors of disorganized thinking, no physical or verbal behaviors toward others, was ambulatory without assistive devices and required stand by assistance for ADLs. Record review of Resident #1's care plan, revised on 02/03/25, reflected [Resident #1] has impaired cognitive function or impaired thought process related Alzheimer's/dementia, mental disorder.Interventions. Use the resident's preferred name. Identity yourself at each interaction. Face the resident when speaking and make eye contact. Reduce any distractions.The resident understands consistent, simple, directive sentences. Provide the resident with necessary cues-stop and return if agitated.Keep the residents routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Record review of Provider Investigation Report (Form 3613-A of Texas Health and Human Services) dated 04/04/2025 reflected, . on 03/30/25 at approximately 07:00 p.m. the DON notified the Administrator that CNA B alleged the CNA A pushed Resident #1 causing her to fall and bump her head. CNA A denied any such allegation claiming it was incidental contact. CNA A was immediately suspended pending investigation. There was no other known witness to the allegation. On 03/30/25 at 06:45 p.m. LVN C conducted a head-to-toe assessment of Resident #1, noting swelling to Resident #1's right forehead. On 03/30/25 Resident #1 was sent to the hospital where she received a CT scan which revealed no intracranial abnormalities (any deviation of typical structure or function of the brain). Resident #1 was returned to the facility later that evening. On 03/31/25 Resident #1 was seen by Psychiatric services that noted Resident #1 wasn't experiencing any emotional distress. On 03/31/25 The facility called the police and reported the incident to them. Officer D was the reporting officer, and the case number was [PHONE NUMBER]. On 03/31/25 Facility Social Worker conducted safe surveys with all Interviewalbe resident with no negative outcomes. On 03/31/25 The administrator visited Resident #1 who was asleep on the couch in the memory care unit. Resident #1 had a bruise and some swelling to her forehead.The investigation reveals through witness statements and resident statement that the allegation of abuse had been confirmed. The facility immediately suspended the alleged perpetrator once the allegation was made. The facility notified the family, physician, and ombudsman. The facility immediately sent Resident #1 out to the hospital to receive treatment which revealed no abnormalities of the intercranial space. The facility called and filed a report with the local police. The facility's social worker conducted safe surveys with all Interviewalbe residents with no negative outcomes. The facility terminated the alleged perpetrator. The facility conducted in-service with staff on abuse/neglect. Record review of CNA B's written statement dated 03/30/25 reflected, Resident #1 walked up to CNA A while she was sitting down eating a sandwich. [Resident #1] Was asking to call her son on the phone. CNA A told her that the phones were not working. [Resident #1] stated the was BS I know that they are working. CNA A stood up, got in [Resident #1's] face nose to nose and told [Resident #1] to get out of her face and she shoved her. [Resident #1] fell and hit her head on the floor. Record review of CNA A's written statement dated 03/30/25 reflected, I [CNA A] came to work on Sunday March 30th, 2025. I was sitting at table taking my daily meds I take every day after I get to work and eating a half of a sandwich before I get going. At that time, I was approached by [Resident #1] asking she could use the phone like she does every day, but today she was really aggressive and being really bossy and not trying to listen to our answers. She was yelling y'all are damn liars. I was just trying to calm her down and explain to her she can, we gotta [sic] clean up trays and all that and we will. I turned around in my chair she was standing at nurse desk. I get up and stood in front of her trying again to explain we will she got up on me put her face in my