

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/19/2026
NAME OF PROVIDER OR SUPPLIER The Homestead of Denison		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 Reba McEntire Lane 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 - Few	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 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 1 of 4 residents (Resident #1) reviewed for infection control. The facility failed to ensure CNA A, CNA B, and RN C used the required PPE for Resident #1, who was on EBP due to his tube feeding, foley catheter, and open wound, while performing wound care on 07/19/26. This failure could place the residents at risk of cross-contamination and development of infection. Findings included: Record review of Resident #1's Comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included hypertension (elevated blood pressure), neurogenic bladder (a loss of bladder control caused by brain, spinal cord, or nerve damage), type 2 diabetes mellitus (elevated blood sugar), and Cerebrovascular Accident (occurs when blood flow to a part of the brain is interrupted or reduced, depriving brain tissue of oxygen and nutrients) (pressure ulcer of sacral region, and local infection of the skin. Resident had no BIMS score documented and was coded under section C1000- Cognitive Skills for Daily Decision Making at 3 which indicated Severely impaired - never/rarely made decisions. Review of section K: Swallowing/Nutritional Status indicated resident had a feeding tube. Record review of Resident #1's comprehensive care plan initiated on 02/03/26, reflected, [Resident #1] required EBP related to feeding tube, wounds, foley catheter. Goal: EBP care should be maintained for the residents entire stay or until wounds have healed or indwelling medical device is no longer needed. Interventions: . Provide patient standard precautions using gowns and gloves during Dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use and wound care. Record review of Resident #1's Physician Orders Report on 07/19/26 reflected: Nursing intervention: implement and maintain enhanced barrier precautions when performing high contact care activities. Related to indwelling catheter with start dated 11/03/25. Record review of Resident #1's Physician Orders Report on 07/19/26 reflected: Wound Prevention: Apply Triad Cream to Masserated Coccyx Area Cover With Foam Dressing Every Three Days Until Resolved with start date of 07/16/26. Observation on 07/19/26 at 09:45 AM, revealed Resident #1 was on Enhanced barriers precautions. There was signage on the room door that informed visitors/staff he was on enhanced barriers precautions, perform hand hygiene before and after leaving room, necessary PPE to wear in room, and donning/doffing (put on/remove) information. There was a PPE supplies holder hanging over the room door. CNA A and CNA B entered Resident #1's room. Both CNAs washed hands, donned gloves and procced to provide incontinent care for Resident #1 without wearing gowns. Interview with CNA A on 07/19/26 at 10:21 AM, revealed she knew she was supposed to wear a gown for the Resident #1's peri care, but she forgot. She stated she was nervous. She stated she was in-serviced regarding (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 - Few	different type of infection control during orientation. She stated the risk of not wearing proper PPE in enhanced barriers precautions residents' rooms was exposing herself and others to the development of infection and spreading germs from one resident to another resident. Interview with CNA B on 07/19/26 at 10:29 AM, revealed she knew that she supposed to wear a gown for the Resident #1's peri care, but she forgot, because she did not pay attention to the signage in front of the room. She could not recall the last time she had in service on infection control. She stated the risk to residents' cross contamination and development of infection. Observation on 07/19/26 at 09:50 AM, revealed RN C got all supplies ready outside Resident #1's room. RN C entered Resident #1's room, washed hands put on gloves, no gown, explained the procedure to Resident #1 and provided wound care to the sacral area. Interview with RN C on 07/19/26 at 10:21 AM, revealed he was supposed to wear proper PPE (gown and gloves) while performing wound care for Resident #1. He stated failure to follow proper infection control including putting on proper PPE would cause cross contamination and spread of infection. He stated he had done training on infection control, and wound care. In an interview with the DON on 07/19/26 at 1:12 PM, she stated they had in serviced the staff that for anyone with a catheter or tube feeding they were required to wear a gown when performing direct care. She stated the risk was potential spread of multi-drug-resistant organism (MDRO) from resident to resident. She stated he DON and the ADON were responsible for doing routine rounds to monitor staff following proper infection control policy. Record review of the facility's policy, Infection control Policy and Procedure Manual revised August 2007-, dated 3/2024, reflected, Precaution: Enhanced Barrier Precautions- Applies to all residents with any of the following: infection control with an MDRO when contact precautions do not otherwise apply: Wounds and /or indwelling medical devices (e.g. central line, urinary catheter, feeding tube. PPE potential exposure to: during high-contact resident care activities: .changing briefs or assisting with toileting. wound care: any skin opening requiring a dressing. Required PPE: Gloves and gowns prior to the high contact care activity.		