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	03/26/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the comprehensive care plan described the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 (Resident #4 and Resident #54) of 5 residents reviewed for comprehensive care plans. 1. The facility failed to ensure Resident #4's care plan reflected changes with oxygen being continuous to PRN and failed to reflect Resident #4's non-compliance with wearing her oxygen.2. The facility failed to ensure Resident #54's care plan reflected Resident #54 changing the oxygen settings from the physician's ordered 4lpm. This failure could put Residents at risk of receiving unnecessary treatments, not receiving care or services and further decline of their physical health. Findings Include: Resident #4 Review of admission Record for Resident #4 dated 03/26/2026 revealed Resident #4 was an [AGE] year-old female who was admitted to the facility originally on 11/21/2024 and readmitted on [DATE]. Resident #4 was diagnosed with Acute and Chronic Respiratory Failure (long term condition where the lungs cannot maintain adequate oxygen levels or remove carbon dioxide effectively, leading to progressive health complications), Dysphagia following Cerebral Infarction (difficulty swallowing from a complication of a stroke), Chronic Obstructive Pulmonary Disease (chronic airflow blockage, making it difficult to breath), and Alzheimer's Disease (progressive neurodegenerative disorder that primarily affects memory, thinking and behavior, and is the most common cause of dementia). Review of Resident #4's MDS assessment dated [DATE] revealed Resident #4 had a BIMS score of 3 which indicated she was severely cognitively impaired. Resident #4 had received oxygen therapy in the past 14 days. Resident #4 was noted to experience shortness of breath or trouble breathing when lying flat. Review of Resident #4's care plan dated 12/04/2024 revealed Focus [Resident #4] has dx [diagnosis] of COPD.Goal.Will be free of s/sx [signs and symptoms] of respiratory infections through review date .Interventions.OXYGEN SETTINGS per orders.every shift. NOTE: There was no information related to Resident #4's noncompliance with wearing oxygen or changes to her physician's orders for oxygen use. Review of Resident #4's Physician Order Summary Report dated 03/25/2026 revealed Resident #4 was ordered Oxygen Administer continuous oxygen at 2-4L [liters] per NC [nasal cannula], Keep sats > 92% (Per nasal cannula or mask type); may remove for ADLs; Keep HOB [head of bed] elevated for sob [shortness of breath] while laying [sic] flat. The order began on 10/22/2025 and was discontinued on 03/25/2026. Review of Resident #4's Physician Order Summary Report dated 03/26/2026 revealed Resident #4 was ordered Oxygen: Administer oxygen at 2-4 Liters per minute related to SOB SpO2<92% (shortness of breath or with oxygen saturations below 92%) as needed. The order began on 03/26/2026. Review of Resident #4's March MAR revealed Oxygen Administer continuous oxygen at 2-4L [liters] per NC [nasal cannula], Keep sats > 92% (Per nasal cannula or mask type); may remove for ADLs; Keep HOB [head of bed] elevated for sob [shortness of breath] while laying [sic] flat every shift. 03/01/2026-03/25/2026 were signed off by a nurse as oxygen was administered continuously at 2-4liters per minute. Order was discontinued on 03/25/2026. Review of Resident #4's March MAR revealed Oxygen: Administer oxygen at 2-4 Liters per minute related to SOB (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	SpO2<92% (shortness of breath or with oxygen saturations below 92%) as needed. On 03/26/2026 on evening/night shift was signed off as having administered 2-4lpm of oxygen as needed. Observation on 03/24/2026 at 9:55 AM revealed Resident #4 was out of her room. Resident #4's oxygen concentrator was running on 3 1/2 lpm. Resident #4 was not wearing the oxygen. Observation on 03/24/2026 at 10:19 AM revealed Resident #4 was in the activity room putting puzzles together with other residents. Resident #4 had a rollator and no oxygen was attached or with Resident #4. Observation on 03/24/2026 at 11:09 AM revealed Resident #4 was in the dining room waiting for lunch to be served. Resident #4 had a rollator and no oxygen was attached or with Resident #4. Observation on 03/25/2026 at 11:00 AM revealed Resident #4 was in the dining room waiting for lunch to be served. Resident #4 had a rollator and no oxygen was attached or with Resident #4. Observation on 03/26/2026 at 9:41 AM revealed Resident #4 was in the sitting area at the front of the building, with other residents. Resident #4 had a rollator and no oxygen was attached or with Resident #4. Observation on 03/26/2026 at 9:45 AM revealed Resident #4 up walking into her room with her rollator. No oxygen was noted with Resident #4. There were no signs or symptoms of shortness of breath. Interview with DON on 03/26/2026 at 9:43 AM revealed Resident #4 used her oxygen mostly when she was in bed. DON stated there was a time Resident #4 required the oxygen continuously but Resident #4 was non-compliant with wearing her oxygen due to her cognitive status. DON stated there had been no concerns with Resident #4 being short of breath due to being non-compliant with wearing her oxygen or no longer using the oxygen continuously. DON stated she reviewed care plans and stated it was noted as Oxygen per orders under the diagnosis of COPD. DON stated there was no additional information in the care plan regarding Resident #4's non-compliance with wearing her oxygen or the changes in her physician's order for oxygen use. Review of Progress Notes for Resident #4 dated 01/01/2026-03/25/2026 revealed no documentation regarding Resident #4's non-compliance with wearing her oxygen. Resident #54 Review of admission Record for Resident #54 dated 03/24/2026 revealed Resident #54 was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #54 was diagnosed with Chronic Obstructive Pulmonary Disease (chronic airflow blockage, making it difficult to breath), Acute and Chronic Respiratory Failure with Hypercapnia (critical condition where the lungs fail to eliminate carbon dioxide), Emphysema (chronic, progressive lung disease, typically caused by smoking, where air sacs are destroyed, causing severe shortness of breath), Nicotine Dependence (chronic, relapsing brain addiction to tobacco products, driven by nicotine's stimulation of dopamine), Obstructive Sleep Apnea (common, serious disorder where throat muscles relax during sleep, causing the airway to collapse and breathing to repeatedly stop and start) and Type 2 Diabetes Mellitus with Diabetic Autonomic Polyneuropathy (chronic complication where prolonged high blood sugar damages multiple peripheral nerves). Review of Resident #54's MDS assessment dated [DATE] revealed Resident #54 had a BIMS score of 12 which indicated she was moderately cognitively impaired. Resident #54 had received oxygen therapy in the past 14 days. Resident #54 was noted to experience shortness of breath or trouble breathing with exertion, when sitting at rest and when lying flat. Review of Resident #54's care plan dated 12/26/2024 updated on 01/29/2026 revealed Focus [Resident #54] has oxygen therapy and bipap at hs [night] r/t [related to] resp [respiratory] failure, pulmonary emphysema/COPD, pulmonary nodules. Removes O2 on her own. Educated to place in bag, but is noncompliant.Goal.[Resident #54] will have no s/sx [signs and symptoms] of poor oxygen absorption through the review date.Interventions.For resident who should be ambulatory, provide extension tubing or portable oxygen apparatus.Observe for s/sx of respiratory distress and report the MD PRN [doctor as needed]: Respirations, Pulse, oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis [excessive, generalized sweating unrelated to heat or exercise], Headaches, Lethargy, Confusion, Atelectasis [partial or complete collapse of a lunching], Hemoptysis [coughing up of blood or blood-stained mucus from lungs or airways often caused by infections like bronchitis or tuberculosis], Cough, Pleuritic pain [sharp, stabbing or burning pain that intensifies with breathing, coughing or sneezing, caused by inflammation of lung lining], Accessory (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	muscle usage, Skin color.OXYGEN SETTINGS per orders.Focus.[Resident #54] has altered respiratory status/difficulty breathing r/t COPD, resp failure, Multiple pulmonary nodules, Pulmonary emphysema .Goal.[Resident #54] will have no complications related to SOB though [sic] the review date. OXYGEN SETTINGS: Oxygen: Administer continuous oxygen at [4 LPM] Liters per (PER NASAL CANNULA; MAY REMOVE FOR ADLS; KEEP HOB ELEVATED FOR SOB WHILE LAYING FLAT).NOTE: There was no information regarding Resident #54 changing the oxygen settings. Review of Resident #54's Physician Order Summary Report dated 03/24/2026 revealed Resident #54 was ordered Oxygen Administer continuous oxygen at (4LPM) Liters per (PER NASAL CANNULA; MAY REMOVE FOR ADLS; KEEP HOB [head of bed] ELEVATED FOR SOB [shortness of breath] WHILE LAYING [sic] FLAT every shift. The order began on 11/30/2024. Review of Resident #54's March MAR revealed Oxygen: Administer continuous oxygen at (4LPM) Liters per (PER NASAL CANNULA: MAY REMOVE FOR ADLS; KEEP HOB ELEVATED FOR SOB WHILE LAYING FLAT) every shift. March 1, 2026-March 24, 2026 were signed off by a nurse as oxygen was administered continuously at 4liters per minute. Review of Resident #54's Progress Notes from 02/01/2026 to 03/25/2026 revealed no information regarding Resident #54 being educated over oxygen concentrator settings or the oxygen settings being changed by the resident. Observation on 03/24/2026 at 9:50 AM revealed Resident #54 sitting in her recliner in her room. Resident #54 was receiving oxygen via nasal cannula at 6lpm. Resident #54 stated she should have her oxygen on 5 1/2lpm but stated she turns the oxygen up to 6lpm to catch her breath. Observation on 03/25/2026 at 11:33 AM revealed Resident #54 had come inside from smoking. Resident #54 stated she was waiting for the nurse to come to administer her nebulizer treatment. Resident #54's oxygen concentrator was set on 5lpm. Observation and interview with LVN B on 03/25/2026 at 11:44 AM revealed she had worked at the facility since September 2025. LVN B stated the facility's policy was to check the concentrator setting one time per shift. LVN B stated she randomly checked each resident on oxygen concentrator settings throughout her shift (6:00 AM to 6:00 PM). LVN B stated she had not checked Resident #54's oxygen settings that day. LVN B stated Resident #54's physician's order was for 4lpm but Resident #54 would change the settings several times throughout the day. LVN B stated Resident #54 had to be re-educated and the oxygen settings turned down. LVN B checked the EHR and verified Resident #54 was ordered 4lpm via nasal cannula. Together with LVN B observation was made of Resident #54's oxygen concentrator's settings. LVN B stated Resident #54's concentrator was set to almost 5lpm. LVN B turned down the setting to 4lpm and explained to Resident #54 that she needed to make sure the oxygen settings remained on 4lpm. As LVN B was leaving Resident #54's room she explained Resident #54 liked to turn her oxygen up to 6lpm. LVN B stated this was a concern because turning the oxygen concentrator settings up too high could cause Resident #54's blood to be over oxygenated and could cause Resident #54's breathing to be altered. Interview with DON on 03/25/2026 at 12:02 PM revealed nurses should be checking the oxygen settings on each resident's oxygen concentrators each shift. DON stated Resident #54 liked to turn up their oxygen settings. Each time this was found DON stated she expected the nurse to educate the resident and turn it back down. DON stated Resident #54 had been educated on numerous occasions, including having the hospice chaplain meet with Resident #54. DON stated oxygen settings should follow physician's order because there was a risk of causing respiratory distress. DON stated there should be a care plan for Resident #54's non-compliance with oxygen settings. DON stated she thought she updated the care plan at the same time it was documented that Resident #54 was non-compliant with bagging her nasal cannula when it was not in use. DON reviewed the care plans in the EHR and confirmed there was no mention in the care plan regarding Resident #54's known behavior of changing her oxygen settings. Review of Goals and Objectives, Care Plans dated 03/20/2025 revealed Policy StatementCare plans shall incorporate goals and objectives that lead to the residents' highest obtainable level of independence.Policy Interpretation and Implementation1. Care plan goals and objectives are defined as the desired outcome for a specific resident problem.2. When goals and objectives are not achieved, the resident's clinical record will be documented as to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	why the results were not achieved and what new goals and objectives have been established. Care plans will be modified accordingly.3. Care plan goals and objectives are derived from information contained in the resident's comprehensive assessment and:a. Are resident oriented.b. Are behaviorally stated.c. Are measurable; andd. Contain timetables to meet the residents' needs in accordance with the comprehensive assessment.4. Goals and objectives are entered into the resident's care plan so that all disciplines have access to such information and can report whether or not the desired outcomes are being achieved.5. Goals and objectives are reviewed and/or revised:a. When there has been a significant change in the residents' condition.b. When the desired outcome has not been achieved.c. When the resident has been readmitted to the facility from a hospital/ rehabilitation stay; andd. At least quarterly.6. The residents have the right to refuse to participate in establishing care plan goals and objectives. When such refusals are made, appropriate documentation will be entered into the resident's clinical records in accordance with established policies.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who needed respiratory care were provided with such care, consistent with professional standards of practice and the comprehensive person-centered care plan, for two of four residents (Resident #4 and #54) reviewed for quality of care. The facility failed to ensure the supplemental oxygen was provided at the physician ordered rate for Residents #4 and #54. This failure could place residents who received oxygen therapy at risk of oxygen toxicity.Findings included: Resident #4 Review of admission Record for Resident #4 dated 03/26/2026 revealed Resident #4 was an [AGE] year-old female who was admitted to the facility originally on 11/21/2024 and readmitted on [DATE]. Resident #4 was diagnosed with Acute and Chronic Respiratory Failure (long term condition where the lungs cannot maintain adequate oxygen levels or remove carbon dioxide effectively, leading to progressive health complications), Dysphagia following Cerebral Infarction (difficulty swallowing from a complication of a stroke), Chronic Obstructive Pulmonary Disease (chronic airflow blockage, making it difficult to breath), and Alzheimer's Disease (progressive neurodegenerative disorder that primarily affects memory, thinking and behavior, and is the most common cause of dementia). Review of Resident #4's MDS assessment dated [DATE] revealed Resident #4 had a BIMS score of 3 which indicated she was severely cognitively impaired. Resident #4 had received oxygen therapy in the past 14 days. Resident #4 was noted to experience shortness of breath or trouble breathing when lying flat. Review of Resident #4's care plan dated 12/04/2024 revealed Focus [Resident #4] has dx [diagnosis] of COPD.Goal.Will be free of s/sx [signs and symptoms] of respiratory infections through review date .Interventions.OXYGEN SETTINGS per orders.every shift. Review of Resident #4's Physician Order Summary Report dated 03/25/2026 revealed Resident #4 was ordered Oxygen Administer continuous oxygen at 2-4L [liters] per NC [nasal cannula], Keep sats > 92% (Per nasal cannula or mask type); may remove for ADLs; Keep HOB [head of bed] elevated for sob [shortness of breath] while laying [sic] flat. The order began on 10/22/2025 and was discontinued on 03/25/2026. Review of Resident #4's Physician Order Summary Report dated 03/26/2026 revealed Resident #4 was ordered Oxygen: Administer oxygen at 2-4 Liters per minute related to SOB SpO2<92% (shortness of breath or with oxygen saturations below 92%) as needed. The order began on 03/26/2026. Review of Resident #4's March MAR revealed Oxygen Administer continuous oxygen at 2-4L [liters] per NC [nasal cannula], Keep sats > 92% (Per nasal cannula or mask type); may remove for ADLs; Keep HOB [head of bed] elevated for sob [shortness of breath] while laying [sic] flat every shift. 03/01/2026-03/25/2026 were signed off by a nurse as oxygen was administered continuously at 2-4liters per minute. Order was discontinued on 03/25/2026. Review of Resident #4's March MAR revealed Oxygen: Administer oxygen at 2-4 Liters per minute related to SOB SpO2<92% (shortness of breath or with oxygen saturations below 92%) as needed. On 03/26/2026 on evening/night shift was signed off as Resident #4 received 2-4 liters per minute of oxygen as needed. Observation on 03/24/2026 at 9:55 AM revealed Resident #4 was out of her room. Resident #4's oxygen concentrator was running on 3 1/2 lpm [liters per minute]. Resident #4 was no wearing the oxygen Observation on 03/24/2026 at 10:19 AM revealed Resident #4 was in the activity room putting puzzles together with other resident. Resident #4 had a rollator and no oxygen was attached or with Resident #4. Observation on 03/24/2026 at 11:09 AM revealed Resident #4 was in the dining room waiting for lunch to be served. Resident #4 had a rollator and no oxygen was attached or with Resident #4. Observation on 03/25/2026 at 11:00 AM revealed Resident #4 was in the dining room waiting for lunch to be served. Resident #4 had a rollator and no oxygen was attached or with Resident #4. Observation on 03/26/2026 at 9:41 AM revealed Resident #4 was in the sitting area at the front of the building, with other residents. Resident #4 had a rollator and no oxygen was attached or with Resident #4. Observation on 03/26/2026 at 9:45 AM revealed Resident #4 up walking into her room with her (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rollator. No oxygen was noted with Resident #4. There were no signs or symptoms of shortness of breath. Interview with DON on 03/26/2026 at 9:43 AM revealed Resident #4 used her oxygen mostly when she was in bed. DON stated there was a time Resident #4 required the oxygen continuously but Resident #4 was non-compliant with wearing her oxygen due to her cognitive status. DON stated due to Resident #4 being non-compliant and Resident #4 doing better than she had been the order was changed to as needed instead of continuous on the evening of 03/25/2026. DON stated there had been no concerns with Resident #4 being short of breath due to being non-compliant with wearing her oxygen or no longer using the oxygen continuously. Review of Progress Notes for Resident #4 dated 01/01/2026-03/25/2026 revealed no documentation regarding Resident #4's non-compliance with wearing her oxygen. Interview with DON on 03/26/2026 at 10:24 AM revealed Resident #4's oxygen orders were changed on 03/25/2026 to reflect her need for oxygen on an as needed basis. DON stated she reviewed the care plan which indicated oxygen was per physician orders. Resident #54 Review of admission Record for Resident #54 dated 03/24/2026 revealed Resident #54 was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #54 was diagnosed with Chronic Obstructive Pulmonary Disease (chronic airflow blockage, making it difficult to breath), Acute and Chronic Respiratory Failure with Hypercapnia (critical condition where the lungs fail to eliminate carbon dioxide), Emphysema (chronic, progressive lung disease, typically caused by smoking, where air sacs are destroyed, causing severe shortness of breath), Nicotine Dependence (chronic, relapsing brain addiction to tobacco products, driven by nicotine's stimulation of dopamine), Obstructive Sleep Apnea (common, serious disorder where throat muscles relax during sleep, causing the airway to collapse and breathing to repeatedly stop and start) and Type 2 Diabetes Mellitus with Diabetic Autonomic Polyneuropathy (chronic complication where prolonged high blood sugar damages multiple peripheral nerves). Review of Resident #54's MDS assessment dated [DATE] revealed Resident #54 had a BIMS score of 12 which indicated she was moderately cognitively impaired. Resident #54 had received oxygen therapy in the past 14 days. Resident #4 was noted to experience shortness of breath or trouble breathing with exertion, when sitting at rest and when lying flat. Review of Resident #54's care plan dated 12/26/2024 updated on 01/29/2026 revealed Focus [Resident #54] has oxygen therapy and bipap at hs [night] r/t [related to] resp [respiratory] failure, pulmonary emphysema/COPD, pulmonary nodules. Removes O2 on her own. Educated to place in bag, but is noncompliant.Goal.[Resident #54] will have no s/sx [signs and symptoms] of poor oxygen absorption through the review date.Interventions.For resident who should be ambulatory, provide extension tubing or portable oxygen apparatus.Observe for s/sx of respiratory distress and report the MD PRN [doctor as needed]: Respirations, Pulse, oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis [excessive, generalized sweating unrelated to heat or exercise], Headaches, Lethargy, Confusion, Atelectasis [partial or complete collapse of a lunching], Hemoptysis [coughing up of blood or blood-stained mucus from lungs or airways often caused by infections like bronchitis or tuberculosis], Cough, Pleuritic pain [sharp, stabbing or burning pain that intensifies with breathing, coughing or sneezing, caused by inflammation of lung lining], Accessory muscle usage, Skin color.OXYGEN SETTINGS per orders.Focus.[Resident #54] has altered respiratory status/difficulty breathing r/t COPD, resp failure, Multiple pulmonary nodules, Pulmonary emphysema .Goal.[Resident #54] will have no complications related to SOB though [sic] the review date. OXYGEN SETTINGS: Oxygen: Administer continuous oxygen at [4 LPM] Liters per (PER NASAL CANNULA; MAY REMOVE FOR ADLS; KEEP HOB ELEVATED FOR SOB WHILE LAYING FLAT). NOTE: There was no information regarding Resident #54 changing the oxygen settings.Review of Resident #54's Physician Order Summary Report dated 03/24/2026 revealed Resident #54 was ordered Oxygen Administer continuous oxygen at (4LPM) Liters per (PER NASAL CANNULA; MAY REMOVE FOR ADLS; KEEP HOB [head of bed] ELEVATED FOR SOB [shortness of breath] WHILE LAYING [sic] FLAT every shift. The order began on 11/30/2024. Review of Resident #54's March MAR revealed Oxygen: Administer continuous oxygen at (4LPM) Liters per (PER NASAL CANNULA: MAY REMOVE FOR ADLS; KEEP HOB (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ELEVATED FOR SOB WHILE LAYING FLAT) every shift. March 1, 2026-March 24, 2026 were signed off by a nurse as oxygen was administered continuously at 4liters per minute. Observation on 03/24/2026 at 9:50 AM revealed Resident #54 sitting in her recliner in her room. Resident #54 was receiving oxygen via nasal cannula at 6lpm. Resident #54 stated she should have her oxygen on 5 1/2lpm but stated she turns the oxygen up to 6lpm to catch her breath. Observation on 03/25/2026 at 11:33 AM revealed Resident #54 had come inside from smoking. Resident #54 stated she was waiting for the nurse to come to administer her nebulizer treatment. Resident #54's oxygen concentrator was set on 5lpm. Observation and interview with LVN B on 03/25/2026 at 11:44 AM revealed she had worked at the facility since September 2025. LVN B stated the facility's policy was to check the concentrator setting one time per shift. LVN B stated she randomly checked each resident on oxygen concentrator settings throughout her shift (6:00 AM to 6:00 PM). LVN B stated she had not checked Resident #54's oxygen settings that day. LVN B stated Resident #54's physician's order was for 4lpm but Resident #54 would change the settings several times throughout the day. LVN B stated Resident #54 had to be re-educated and the oxygen settings turned down. LVN B checked the EHR and verified Resident #54 was ordered 4lpm via nasal cannula. Together with LVN B observation was made of Resident #54's oxygen concentrator's settings. LVN B stated Resident #54's concentrator was set to almost 5lpm. LVN B turned down the setting to 4lpm and explained to Resident #54 that she needed to make sure the oxygen settings remained on 4lpm. As LVN B was leaving Resident #54's room she explained Resident #54 liked to turn her oxygen up to 6lpm. LVN B stated this was a concern because turning the oxygen concentrator settings up too high could cause Resident #54's blood to be over oxygenated and could cause Resident #54's breathing to be altered. Interview with DON on 03/25/2026 at 12:02 PM revealed nurses should be checking the oxygen settings on each resident's oxygen concentrators each shift. DON stated Resident #54 liked to turn up their oxygen settings. Each time this was found DON stated she expected the nurse to educate the resident and turn it back down. DON stated Resident #54 had been educated on numerous occasions, including having the hospice chaplain meet with Resident #54. DON stated oxygen settings should follow physician's order because there was a risk of causing respiratory distress. Review of Oxygen Administration dated revised February 2025 reflected Purpose The purpose of this procedure is to provide guidelines for safe oxygen administration, and infection prevention associated with respiratory therapy tasks, Preparation1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess any special needs of the resident.3. Assemble the equipment and supplies as needed.General Guidelines1. Oxygen therapy is administered by an oxygen mask, nasal cannula, and/or nasal catheter.a. The oxygen mask is a device that fits over the resident's nose and mouth. It is held in place by an elastic band placed around the resident's head.b. The nasal cannula is a tube that is placed into the resident's nose. It is held in place by an elastic band placed around the resident's head.c. The nasal catheter is a piece of tubing inserted through the resident's nostrils into the back of his/her mouth. It is held in place by a piece of skin tape attached to the resident's forehead and/or cheek.AssessmentBefore administering oxygen, and while the resident is receiving oxygen therapy, assess for the following:1. Signs or symptoms of cyanosis (i.e., blue tone to the skin and mucous membranes);2. Signs or symptoms of hypoxia (i.e., rapid breathing, rapid pulse rate, restlessness, confusion).3. Signs or symptoms of oxygen toxicity (i.e., tracheal irritation, difficulty breathing, or slow, shallow rate of breathing).4. Vital signs.5. Lung sounds.6. Oxygen saturation, if applicable; and7. Other laboratory results, if applicable.ReportingNotify the Physician or Nurse Practitioner if the resident refuses the procedure.

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	675212	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Homestead of Denison	1101 Reba McEntire LN Denison, TX 75020

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety for the facility's only kitchen in that: The facility dietary staff failed to ensure temperatures were taken of all hot and cold foods before serving them to residents during lunch meal service on 3/24/26.The facility dietary staff failed to ensure the potato salad was at the proper holding temperature for lunch service on 3/24/26.The facility dietary staff failed to ensure all seasonings used for food preparation were not past the used by date. These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness if consumed and food contamination.Record review of the facility recipe Apple Crisp dated 10/22/25 reflected .May serve warm or cold. Critical Control Point - Maintain at an internal temperature of less than 41 Fahrenheit. Critical Control Point - Reheat: To an internal temperature of 165 Fahrenheit held for 15 seconds, within 2 hours one time only. Record review of the facility recipe Potato Salad dated 10/22/25 reflected .serve cold, 1/2 cup each. Critical Control Point - Maintain at an internal temperature of less than 41 Fahrenheit. An observation and interview with the Dietary Manager in the kitchen on 03/24/2026 at 9:00 a.m. revealed Dill Weed spice container about 1/3 full, with a written date of 1/4/25 and a used by date of 6/30/25. The Dietary Manager revealed the written date on the container was the date the dietary staff opened Dill Weed. The used by date was the date the item should have been used by and discarded. The Dietary Manager stated if the item was past the used by date she would check the color and smell to determine if it should have been used. The Dietary Manager immediately threw the Dill Weed away. The Dietary Manager stated she had kept the spice in case she needed it, but it was only being used for a recipe they no longer had. The Dietary Manager stated she had not used Dill Weed in a long time. An observation and interview of Dietary Aide A in the kitchen taking food temperatures on 3/24/26 at 10:33 a.m. revealed the Potato salad was 103.2 Fahrenheit. Dietary Aide A proceeded to put the potato salad on the steam table in a bed of ice. Dietary Manager intervened and stated the salad should have been cold and would put it back in the freezer until it was time to serve at 11:00 a.m. to give it an opportunity to cool down. The Dietary Manager took the salad and placed it in the freezer. At 10:48 a.m. the Dietary Manager took some okra out of the fryer and poured them onto the steam table without temping them. At 10:56 a.m. the Dietary Manager took the temperature of the potato salad again and it was at 92.6 Fahrenheit. The Dietary Manager then put the potato salad in the serving area on ice and Dietary Aide A stated she was ready to serve. The Surveyor intervened and told Dietary Aide A they should not serve the potato salad because it was not held at the appropriate temperature. Dietary Aide A told the Dietary Manager they could not serve the potato salad and the Dietary Manager stated they would substitute it out for potato chips. The Dietary Manager removed the potato salad from the service area then got the potato chips and began portioning them out to serve the trays. At 11:03 a.m. Dietary Aide A served the first tray with the fried okra and an unknown staff put the plate of food on a tray with a covered apple dessert. The apple desserts were not temped prior to serving and had been on the racks since 10:33am. An observation of the lunch test tray on 03/24/2026 at 12:31p.m. revealed the following items: water, tea, potato chips, apple cobbler, sloppy joe with bun and fried okra. The Dietary Manager and 2 surveyors tasted the food. The apple cobbler was cool and at room temperature. The okra was hot. Interview with the Dietary Manager on 03/24/2026 at 12:33 PM revealed all foods should have been temped including hot and cold foods prior to serving. The Dietary Manager stated hot foods should have a temperature higher than 160 degrees and cold foods should have a temp lower than 40 degrees. The Dietary Manager stated the cobbler should have been hot, but she had no way to keep it hot after cooking it that morning. The Dietary Manager stated she temped the apple cobbler when she cooked it that morning but had not temped it prior to food service. The Dietary Manager recalled temping the okra (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	but noted she had made several batches of okra and did not temp all of the batches of okra that day. The Dietary Manager stated if foods were not temped appropriately the food could have been cold or too hot. The Dietary Manager stated not having had the potato salad at the right temperature could have resulted in residents getting sick. The Dietary Manager was unsure of the reason the potato salad was so hot, as she typically made it the day of and was usually cold at lunch. The Dietary manager stated she had thrown out the potato salad and the Dill Weed seasoning. The Dietary Manager stated the risk to the residents of possibly using expired seasoning would have been it could have made them sick. An interview with the Administrator on 03/26/2026 at 11:26 AM revealed the expectation was all food should have been temped prior to serving and any food in the danger zone should have not been served. The Administrator stated hot food should have been hot and cold foods should have been cold. The risk to the residents of foods not having been at the appropriate temperature was food borne illness. The Administrator stated the expectation for seasonings used for food preparation was they should have been labeled on the outside with the expiration date and the dietary staff should have been checking the seasonings every time they use it to ensure it had not passed the used by date. The Administrator stated the risk to the residents of using expired seasonings could haveaffected the quality and taste of the food. The Administrator stated he frequently tasted the food to ensure quality and planned on in-servicing the dietary staff on food temps, following recipes and ensuring all fried foods were temped. Requested facility policy related to expiration dates and used by date from the Administrator on 3/24/26 but was informed they did not have a policy specifically related to it. The facility did not submit a policy by the date and time of exit. Record review of the facility policy Food Preparation and Service revised July 2014 reflected .1. The danger zone for food temperatures is between 41 Fahrenheit and 135 Fahrenheit. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness.3. The longer foods remain in the danger zone the greater the risk for growth of harmful pathogens. Therefore, potentially hazardous food must be maintained below 41 Fahrenheit or above 135 Fahrenheit. Potentially hazardous foods held in the danger zone for more than 4 hours (if being prepared from ingredients at room temperature) or 6 hours (if cooked and then cooled) may cause foodborne illness. 5. The following internal cooking temperatures/times for specific foods must be reached to kill or sufficiently inactivate pathogenic microorganisms: Poultry and stuffed foods - 165 Fahrenheit. Ground meat, ground fish and eggs held for service - at least 115 Fahrenheit. Fish and other meats - 145 Fahrenheit for 15 seconds. Fresh, frozen or canned fruits/vegetables - 135 Fahrenheit. Unpasteurized eggs - until all parts of the egg (yolks and whites) are completely firm (160 Fahrenheit) Foods cooked in a microwave - 165 Fahrenheit in all parts of the food. It is critical to measure the food temperature at multiple sites and allow the food to stand covered for two (2) minutes after microwave heating.6. Previously cooked food must be reheated to an internal temperature of 165 Fahrenheit for at least 15 seconds. Re-heated foods that are not consumed within 2 hours will be discarded . 3. The temperature of foods held in steam tables will be monitored by food service staff.9. Snacks will not be left on trays or countertops beyond the established safe time and temperature requirements.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 resident (Resident #2) of 5 residents reviewed for ADLs. The facility failed to ensure Resident #2 had his fingernails trimmed on both hands on 03/24/2026. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and skin breakdown, and a decreased quality of life.Record Review of Resident #2's Quarterly MDS assessment dated [DATE] reflected a [AGE] year-old male with initial admission date of 11/20/2020 to the facility. His pertinent diagnoses included: hemiplegia (paralysis that affects one side of the body, causing severe or total loss of motor function in the arm, leg, and sometimes face) affecting right dominant side, hyperkalemia (elevated potassium), Diabetes mellitus (elevated blood glucose levels), cerebral infarction (is a condition caused by a blockage in blood vessels supplying the brain, resulting in tissue death). His cognitive skills for daily decision making were severely impaired. The BIMS score was 99, which indicated Resident #2 was unable to complete the interview. Resident #2 was dependent on staff for his personal hygiene. Review of Resident #2 's Comprehensive Care Plan, revised 11/17/2025 reflected, Focus: [Resident #2] requires assist with ADLs related to . CVA (cerebral infarction) with residual effects, right sided hemiplegia.Interventions: Hygiene: [Resident #2] requires total assistance with personal . In an observation on 03/24/2026 at 11:28 AM revealed Resident #2 had long and jagged nails on both hands measuring approximately 0.2 - 0.4 inches in length extending from the tip of his fingers. Resident #2 was not verbal. In an interview on 03/25/2026 at 9:20 AM with LVN C stated that Nurses and CNAs were responsible for clipping residents' fingernails. She stated that for residents with diabetes, Nurses were responsible for trimming fingernails as needed. LVN C stated the risks of long, dirty fingernails included skin tears, increased risk of infection and decreased quality of life. In an interview on 03/26/2026 at 9:18 AM, the DON stated her expectation was that ADL care be provided as needed, particularly during shower days. She stated that CNAs were responsible for providing nail care, including trimming fingernails, unless the resident had a diagnosis of diabetes. She stated that charge nurses were responsible for monitoring this care. The DON stated that residents having long, dirty fingernails could result in skin breakdown, potential of infections and dignity concerns. Record review of the facility policy Care of Fingernails/Toenails, revised in October 2010 reflected The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections . Nail care includes daily cleaning and regular trimming .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to label drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 (Med Cart Hall 400) of 2 medication carts reviewed for pharmacy services in that: The facility failed to ensure LVN F responsible for Nurses Cart Hall 400, removed medications in unsecure containers from the Nurses Cart. This failure could affect residents resulting in diminished effectiveness, and not receiving the therapeutic benefits of the medications, and place residents at risk of not having the medication available due to possible drug diversion.Record review and observation on 03/24/26 at 10:20 AM of Med Cart Hall 400, with LVN F revealed the blister pack for Resident #21's lorazepam 0.5 mg tablet (controlled medication used for anxiety) had 1 blister seal broken and the pill still inside the broken blister. Interview on 03/24/26 at 10:30 AM, LVN F stated the count was done at shift change and the count was correct. She stated she did not check the blister packs during the count. She stated she was unaware when the blister pack seal was broken, and she was not aware of who might have damaged the blister. She stated the risk would be potential for drug diversion. She stated the nurses were responsible for checking the medication blister packs for broken seals during the count of narcotics during the change of shift. She stated when a broken seal was observed, she would waste the pill with another nurse. At an interview on 03/26/26 at 9:18 AM, the DON stated that if a blister pack medication seal was broken the pill would be discarded. The DON stated it would not be acceptable to keep a pill in a blister pack that was opened. The DON stated the risk would be potential for drug diversion and infection control issues. She stated nurses were responsible for checking the medication blister packs for broken seals during the count on the change of shifts. The DON stated she was supposed to check the carts daily. The DON stated the pharmacy consultant checked the carts monthly and she would be doing random checks of the medication carts for monitoring. Record review of the facility's policy titled Storage of Medications, revised April 2019, revealed in part . Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy . Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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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 control program designed to prevent the development and transmission of infection for 1 resident (Resident #71) of 3 observed for infection control. The facility failed to ensure CNA D changed gloves and completed hand hygiene during incontinent care for Resident #71 on 3/25/26. These failures could place residents at risk for infection and cross contamination of pathogens and illness.Record review of Resident #71's Comprehensive MDS assessment dated [DATE] reflected Resident #71 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including cerebral infarction (a condition caused by a blockage in blood vessels supplying the brain, resulting in tissue death), hemiplegia (paralysis that affects one entire side of the body causing severe loss of muscle function, strength, and control) affecting left side, and elevated blood pressure. Resident #71's BIMS score was 99, which indicated Resident #71 was unable to complete the interview. The MDS assessment indicated Resident #71 required maximal assistance with toileting hygiene. Observation on 03/25/26 at 1:24 PM revealed CNA D and CNA F entered Resident #71's room to provide incontinence care. Both CNAs washed their hands and donned gloves, CNAD unfastened Resident #71's brief, she then provided peri-care to the resident, wiping across the resident's pubis bone and then down each groin. She rolled resident on her side, CNA E supported resident when she was on her side. CNA D wiped the resident's buttock area with peri-wipes, front to back, she then removed the soiled brief and with soiled gloves, placed the clean brief under the resident. She rolled the resident on her back onto the clean brief. Once finished, she fastened the resident's brief. Without changing gloves CNA D covered resident and she lowered the resident's bed to low position. Both CNAs removed and discarded gloves and washed their hands. In an interview on 03/25/26 at 1:47 PM, CNA D stated she should change her gloves and perform hand hygiene when she went from dirty to clean. CNA D stated failing to provide proper care exposed the residents to infections. In an interview on 03/26/26 at 9:18 AM, the DON stated she expected the staff to remove their gloves and sanitize their hands when going from dirty to clean. She stated CNAs were trained to perform hand hygiene between change of gloves. She stated failure to do so would potentially lead to cross-contamination and possible spread of infection. She stated she would educate all nursing staff and she would do random rounds for monitoring. Record review of the facility's policy, Hand Washing/Hand Hygiene, revised December 2023, reflected, .Use an alcohol-based hand rub or water for the following situations . Before moving from a contaminated body site to a clean body site during resident care .