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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675712	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER: Homestead Nursing and Rehabilitation of Itasca		STREET ADDRESS, CITY, STATE, ZIP CODE: 409 S Files St Itasca, TX 76055	

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49065 Based on observation, interview, and record review the facility failed to maintain the resident's privacy during wound treatments for 2 of 2 resident (Residents #8 and #13) reviewed for privacy. The facility failed to ensure Dr-B and the ADON protected the resident's privacy by closing the curtain and/or the resident's door when performing wound care on Resident #8 and Resident #13. This failure could place residents at risk for embarrassment, shame, and loss of dignity. Findings include: Record review of Resident #8's undated face sheet, revealed she was an [AGE] year-old female admitted [DATE] with diagnoses of Pressure ulcer Stage 3 (skin damage extending into muscle) depression, Hyponatremia (low sodium), Dementia, and Fracture of the lower leg. Record review of Resident #8's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 9, which indicated the resident's cognitive ability was moderately impaired. Record review of Resident #8's Care Plan dated 8/6/24 reflected a Focus area was initiated for Dementia on 5/24/2018 with a goal to maintain current level of cognitive function. Resident #8's interventions included to promote dignity, converse with resident, and maintain privacy while providing care. Record review of Resident #13's undated face sheet, revealed she was a [AGE] year-old female admitted [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease (lung disease), Muscle Wasting, and Abnormality of Gait and Mobility. Record review of Resident #13's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 01, which indicated the resident's cognitive ability was severely impaired. Record review of Resident #13's Care Plan dated 6/25/2024 reflected a Focus area was initiated for Dementia on 1/7/2020 with a goal to maintain current level of cognitive function. Resident #13's interventions included to promote dignity, converse with resident, and ensure privacy while providing care. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #18's undated face sheet, revealed she was a [AGE] year-old female admitted [DATE] with diagnoses of Diabetes Mellitus Type II, Anxiety disorder, depression, and Pressure Ulcer Stage 1 (skin damage is superficial). Record review of Resident #18's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 13, which indicated the resident's cognitive ability was not impaired. Observation on 10/09/2024 at 8:54 a.m. revealed Dr-B and the making wound care rounds and performing wound care on Resident 8. Wound care was in process with the privacy curtain pulled to the right which left a large gap between the wall and the curtain. Roommate Resident 18 was sitting a few feet from the curtain gap and had a view of care and Resident #8's uncovered body. Surveyor observation from the hallway included a full view of Resident #8's uncovered buttock area when she was turned. Staff corrected the curtain several minutes later. Observation on 10/09/2024 at 9:05 a.m. revealed Dr-B and the ADON making wound care rounds and performing wound care on Resident 13. Wound care was performed with the door open completely and people walking up and down the hallway. Resident was visible from the hall as the wound dressing on her foot was done. Progress of the wound was discussed during the treatment. In an interview on 10/10/24 at 12:47 PM CNA-A stated privacy should be protected during all resident's treatments by pulling resident's curtain, closing shades/blinds, covering resident, and closing the door. She stated that would include all wound care treatments. CNA-A stated it was not acceptable at all for roommates to be able to see the other resident's private body areas during treatments. She stated that could cause the resident to feel exposed, embarrassed, and not to feel good. In an interview on 10/10/24 at 1:42 PM LVN -A stated privacy should be protected during all resident treatments by closing the resident's door and curtain, pulling blinds closed, and limiting exposed body areas to only the part that had to be exposed at that time. She stated that would include wound treatments and that it was not acceptable for a roommate to be able to see the other resident's private body areas. LVN-A stated the negative outcome to the resident if privacy was not maintained would be loss of self-esteem and embarrassment. In an interview on 10/10/24 at 1:45 PM the ADMIN stated privacy should be protected during all resident treatments by closing blinds, closing resident's door and curtain. She stated that would include all wound treatments and that it is not acceptable for a roommate to be able to see the other resident's private body areas. The ADMIN stated the negative outcome to the resident if privacy was not maintained would be shame at personal exposure. In an interview on 10/10/24 at 2:13 pm the DON stated that privacy should absolutely be protected during all resident treatments by pulling the curtain, closing the door, and only allowing the nursing personnel needed in the room. She stated that would include wound care treatments and that it was not acceptable for the roommate to be able to see the other resident's private body areas. The DON stated the negative outcome to the resident if privacy was not maintained would be embarrassment and loss of dignity. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility policy titled, Dignity dated 2001 Med-Pass, Inc. with a last revision date of February 2021, reflected the following: Residents are treated with dignity and respect at all times. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45957 Based on interviews and record review the facility failed to ensure assessments accurately reflected the resident's status for 1 of 4 residents (Residents #36) reviewed for resident assessments. The facility failed to ensure Resident #36's Quarterly MDS reflected that Resident #36 primary diagnosis of orthostatic hypotension. This deficient practice could place residents at-risk for inadequate care due to inaccurate assessments. Findings include: A record review of Resident #36's face sheet dated 10/09/24 reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #36's diagnoses included orthostatic hypotension (a type of low blood pressure that occurs when you stand up after sitting or lying down), age related nuclear cataract bilateral (a common cause of blindness in older adults and the elderly), and ocular pain left eye (sharp and throbbing pain in the eye), muscle weakness (loss of muscle strength of the inability to move a muscle normally), and vascular dementia (occurs when the blood vessels in the brain are damaged, causing problems with thinking, memory, and behavior). A record review of Resident #36's Quarterly MDS assessment, dated 08/07/24, reflected the resident had a BIMS score of 06, which indicated severe cognitive impairment. Resident #36's Quarterly MDS did not reflect Resident 36's current primary diagnosis of orthostatic hypotension. A record review of Resident #36's care plan, dated 08/06/2024, did not reflect or address Resident #36's primary diagnosis of orthostatic hypotension. A record review of Resident #36's physician's orders, dated 10/09/2024, reflected Resident #36 had an order dated 06/19/24 for midodrine tablet with special instructions: give at 0700 and at noon. Keep patient sitting or standing for several hours after giving it each time. During an interview with the MDS Coordinator on 10/10/24 at 12:30pm, the MDS Coordinator stated that she was responsible for completing MDS and care plan assessments. The MDS Coordinator stated a Resident #36's MDS assessment should reflected her primary diagnoses of orthostatic hypotension. The MDS Coordinator stated it was mistake she forgot to list Resident #36 primary diagnoses of orthostatic hypotension. The MDS Coordinator stated that if a resident's MDS assessment was inaccurate then the resident may not receive the appropriate care. During an interview with the DON on 10/10/24 at 1:20pm, the DON stated that Resident #36's primary diagnosis of orthostatic hypotension should have been reflected on the MDS assessment dated [DATE]. The DON stated there would be no negative outcome if Resident #36's MDS assessment did not reflect the resident's primary diagnosis because the resident's physician's orders had special instruction when giving her medication for her diagnosis of orthostatic hypotension. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the ADM on 10/10/24 at 1:45pm, the ADM stated that Resident #36's primary diagnosis of orthostatic hypotension should have been reflected on the MDS assessment. The ADM stated that diagnosis of orthostatic hypotension would cause a person to be dizzy or lightheaded due to blood pressure dropping when standing after lying down. The ADM stated that Resident #36's primary diagnose of orthostatic hypotension should be reflected on her most MDS due to the MDS triggering care plan care areas. The ADM stated if Resident #36's MDS was inaccurate that could cause the care plan to be inaccurate as well. The ADM stated it was the MDS nurses' responsibility for completing the MDS assessments and care plans. The ADM stated she expected staff to thoroughly review residents' records to ensure MDS assessments and care plans are completed accurately. A record review of the facility's Resident Assessment policy, dated 2001 revised October 2023, reflected A comprehensive assessment of each resident is completed at intervals designated by OBRA regulations and PPS requirements. Data from the Minimum Data Set (MDS) is submitted to the internet Quality Improvement Evaluation Systems (iQIES) as required. Policy Interpretation and Implementation 1. OBRA Required Assessment are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. OBRA assessment include: a. Admission Assessment. b. Quarterly Assessment. c. Annual Assessment. d. Significant Change in Status Assessment (SCSA). e. Significant Correction to Prior Comprehensive Assessment (SCPA). f. Significant Correction to Prior Quarterly Assessment (SCQA); and g. Discharge Assessment (return anticipated and return not anticipated). 10. Assessment are completed by staff members who have the skills and qualifications to assess relevant care area and who are knowledgeable about the resident's strengths and areas of decline. 11. All persons who have completed any portions of the MDS resident assessment form must sign the document attesting to the accuracy of such information. 12. Information in the MDS assessment will consistently reflect information in the progress notes, plans of care and resident observations/interviews.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45957 Based on interviews and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 4 residents (Residents #36) reviewed for comprehensive care plans. Resident #36's comprehensive care plan did not reflect Resident #36's primary diagnosis of orthostatic hypotension. This deficient practice could place residents at risk for not receiving proper care and services due to inaccurate care plans. Findings include: A record review of Resident #36's face sheet dated 10/09/24 reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #36's diagnoses included orthostatic hypotension (a type of low blood pressure that occurs when you stand up after sitting or lying down), age related nuclear cataract bilateral (a common cause of blindness in older adults and the elderly), and ocular pain left eye (sharp and throbbing pain in the eye), muscle weakness (loss of muscle strength of the inability to move a muscle normally), and vascular dementia (occurs when the blood vessels in the brain are damaged, causing problems with thinking, memory, and behavior). A record review of Resident #36's Quarterly MDS assessment, dated 08/07/24, reflected the resident had a BIMS score of 06, which indicated severe cognitive impairment. Resident #36's Quarterly MDS did not reflect Resident 36's current primary diagnosis of orthostatic hypotension. A record review of Resident #36's care plan, dated 08/06/2024, did not reflect or address Resident #36's primary diagnosis of orthostatic hypotension. A record review of Resident #36's physician's orders, dated 10/09/2024, reflected Resident #36 had an order dated 06/19/24 for midodrine tablet with special instructions: give at 0700 and at noon. Keep patient sitting or standing for several hours after giving it each time. During an interview with the MDS Coordinator on 10/10/24 at 12:30pm, the MDS Coordinator stated that she was responsible for completing MDS and care plan assessments. The MDS Coordinator stated a Resident #36's care plan should have reflected the residents' primary diagnosis of orthostatic hypotension. The MDS Coordinator stated that if a resident's care plan was inaccurate then the resident may not receive the appropriate care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 10/10/24 at 1:20pm, the DON stated that Resident #36's primary diagnosis of orthostatic hypotension should have been reflected on the resident care plan. The DON stated there would be no negative outcome if Resident #36's care plan did not reflect the resident primary diagnosis because the resident's physician's orders had special instruction when giving her medication for her diagnosis of orthostatic hypotension. During an interview with the ADM on 10/10/24 at 1:45pm, the ADM stated that Resident #36's primary diagnosis of orthostatic hypotension should have been reflected on the resident care plan. The ADM stated it was the MDS nurses' responsibility for completing the MDS assessments and care plans. The ADM stated she expected staff to thoroughly review residents' records to ensure MDS assessments and care plans are completed accurately. The ADM stated if a resident care plan was inaccurate that could cause the resident not to receive the proper care. A record review of the facility's Care Plans, Comprehensive Person-Centered policy, dated 2001, reflected A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 1. The interdisciplinary Team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 7. The Comprehensive, person-centered care plan will: a. Include measurable objective and time frames. b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being including: . c. includes the resident's stated goals upon admission and desire outcomes. d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45957 Based on observations, interviews and record review, the facility failed to maintain and ensure safe and sanitary storage of residents' food items for 1 of 12 residents' (Resident #34) refrigerators reviewed. Resident #34's personal in-room refrigerator was not monitored for safe temperatures. This deficient practice could place residents who had personal in-room refrigerators at risk of food borne illnesses. The findings were: A record review of Resident #34's face sheet dated 10/10/24 reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #34's diagnoses included essential hypertension (a type of blood pressure that develops gradually over time and has to clear cause), major depression disorder (a mental health condition that involves a persistent feeling of sadness, loss of interest, or low mood that last for a long time), Gastro-esophageal reflux disease with esophagitis without bleeding (occurs when stomach contents leak back into the esophagus, causing inflammation and damage), paranoid schizophrenia (type of schizophrenia that involves paranoia and delusions) A record review of Resident #34's Quarterly MDS assessment, dated 08/0824, reflected the resident had a BIMS score of 12, which indicated moderate cognitive impairment. During an observation on 10/08/24 at 9:35am, revealed Resident #34 had a personal room refrigerator with no refrigerator temperature log attached. During an observation on 10/08/24 at 11:50am, revealed Resident #34 had a personal room refrigerator with no refrigerator temperature log attached. During an interview with Resident #34 on 10/08/24 at 9:45am, Resident #34 stated that she had not seen a refrigerator temperature log on her refrigerator in months. During an interview with the NA on 10/10/24 at 2:20pm, the NA stated it was the housekeeper's responsibility to document on the resident's personal refrigerator temperature log daily. The NA stated that if a resident's temperature log was not completed daily the resident's refrigerator may not be cooling correctly. The NA stated if the resident's refrigerator was not working properly then the items in the resident's refrigerator would spoil. During an interview with the HK on 10/10/24 at 2:30pm, the HK said that it was the HKs responsibility to document the resident's personal refrigerator temperature daily. The HK stated he was responsible for completing Resident #34's personal refrigerator's temperatures log. The HK stated that he didn't remember if he completed the temperature log or not. The HK stated each resident that had a personal refrigerator should have a temperature log on it for the housekeeping staff to document the temperature daily. The HK stated if temperatures weren't documented daily the refrigerator may not be working properly. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 10/10/24 at 2:50pm, the DON stated that it was the housekeeper's responsibility to document the resident's personal refrigerator's temperature. The DON stated that if a resident's temperature log was not completed daily the refrigerator might not be working properly. During an interview with the ADM on 10/10/24 at 2:55pm, the ADM stated that it was the housekeeper's responsibility to document the resident's personal refrigerator's temperature. The ADM stated that if a resident's temperature log was not completed daily the refrigerator might not be working properly. The ADM stated if a resident's refrigerator was not working properly then that could cause the resident refrigerated items to be spoil or be thrown out. The ADM stated she expect for the housekeepers to document temperatures on the resident's refrigerators daily. A record review of the facility's Refrigerators and Freezers policy, dated 2001 revised November 2022, reflected This facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. Policy Interpretation and Implementation 1. Refrigerators and/pr freezers are maintained in good working condition. Refrigerators keep foods at or below 41 [degrees] F and freezers keep frozen foods frozen solid. 2. Monthly tracking sheets for all refrigerators and freezers are posted to record temperatures.