STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Homestead of Sherman	1000 Sara Swammy Dr Sherman, TX 75090

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 42971

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 2 (Resident #13, Resident #40) of 8 residents reviewed for ADLs.

The facility failed to ensure:

1- Resident #13 had her fingernails cleaned and trimmed.

2- Resident #40 had his fingernails cleaned and trimmed.

This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life.

Findings include:

1- Resident #13

Review of Resident #13's Annual MDS assessment dated [DATE]/2023 reflected Resident #13 was a [AGE] year-old female with initial admitted to the facility on [DATE]. Her diagnoses included coronary artery disease (chronic condition of plaque buildup in heart), hypertension (high blood pressure), heart failure (heart doesn't pump enough blood for body needs), Renal insufficiency (poor functioning of kidneys), Diabetes Mellitus (high blood glucose levels), hyperlipidemia (high blood lipid levels), Cerebral Vascular Accident (stroke), Parkinson disease (chronic and progressive neurological disorder). Resident #13 had a BIMS of 10 which indicated she had moderate cognitive impairment. Resident #13 was always incontinent of bowel and bladder and required assistance with personal hygiene.

Review of Resident #13's Comprehensive Care Plan, revised 03/25/24, reflected the following: Problem: [Resident #13] had ADL self-care deficit related to limited physical mobility. Goal: [Resident #13] will maintain current level of function in personal hygiene. Approach: Bathing: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse.

(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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and Interview on 05/21/24 at 11:22 AM revealed Resident#13 resident's nail on both hands were long and dirty. The fingernails on both hands were 0.75 inches long and dirt under the nail bed. Interview with Resident#13 revealed she would like her fingernails to be trimmed and cleaned. She stated usually the nails were trimmed and cleaned by a Nurse, but the nails have not been cut for more than a month. In an interview with CNA B on 05/21/24 at 11:26 AM revealed she has been in the facility for about a month and both CNAs and LVNs were responsible for nail care. She stated if a resident has diabetes, only nurses were allowed to provide nailcare. She stated the risk for not performing nailcare was increased risk of infection. In an interview with LVN C on 05/21/24 at 11:30 AM revealed Resident #13 was very vocal of her needs and Nurses trim her nails since Resident #13 had diagnosis of diabetes. She stated that she had not offered nailcare to the Resident#13 recently. She stated that nailcare should be provided every Sunday or as needed. She stated Resident #13's fingernails were long and dirty and offered to clean them after the interview. She stated the risk of not providing adequate nail care was increased infections. 2- A record review of Resident #40's Quarterly MDS assessment dated [DATE] reflected Resident #40 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included cerebrovascular accident (a loss of blood flow to part of the brain, which damages brain tissue), hemiplegia (paralysis of one side of the body, contracture of left hand and left shoulder, and speech and language deficit. Resident #40 had a BIMS of 12 which indicated Resident #40's cognition was moderately impaired. He required extensive assistance of two-person physical assistance with personal hygiene. A record review of Resident #40's Comprehensive Care Plan, revised 05/17/24, reflected the following: problem: ADLs Functional status . Personal Hygiene: Assist.: x 1. Goal: Resident will maintain a sense of dignity by being clean, dry, odor free and well groomed. Interventions: Assist with ADLs. An observation and interview on 05/21/24 at 10:56 AM revealed Resident #40 was laying in his bed. The nails on the right hand were approximately 0.3 centimeter in length extending from the tip of his fingers. The nails were discolored tan and the underside had dark brown colored residue. The nails on the left hand were approximately 0.5 centimeter in length extending from the tip of his fingers. Resident #40 was unable to answer questions. Interview on 05/17/23 at 11:02 AM with CNA D revealed CNAs were allowed to cut the residents' nails if they were not diabetic. CNA D stated she would clean and trim Resident #40's nails right then. CNA D stated the risk for not performing nailcare was increased risk of infection. In an interview with the DON on 05/22/24 3:35 PM revealed her expectation was that nail care should be provided every Sunday or as needed, especially during shower time. She stated that CNAs were responsible for doing nail care unless the resident had diagnosis of diabetes. She stated that they utilized agency staffing on weekends and her expectation was weekend supervisor should follow through with nail care. She also stated that as the DON, either herself or her designee were responsible to do routine rounds for monitoring. The DON stated residents having long and dirty fingernails could be an infection control issue. (continued on next page)

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

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NAME OF PROVIDER OR SUPPLIER The Homestead of Sherman		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Sara Swammy Dr Sherman, TX 75090	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of the facility policy titled Activities of Daily Living dated 1, 2023 reflected, . It is the policy of this home to assure residents have their activities of daily living needs met 48560

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 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 (200 hall nurses' medication cart) of 3 medication carts reviewed for pharmacy services. The facility failed to ensure the 200 Hall medication cart had: 1- 1 insulin pen for Resident #175 with an expired opened date. 2- 1 insulin pen for Resident #17 with an expired opened date. These failures could affect residents resulting in diminished effectiveness, and not receiving the therapeutic benefits of the medications. The findings include: 1- Record review of Resident #175's Comprehensive MDS, dated [DATE], revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses included type 2 diabetes mellitus and hyperlipidemia (too many lipids and fats in the blood). She had a BIMS score of 11 indicating her cognition was cognitively moderately impaired. Record review of Resident #175's Medication Administration Records dated [DATE] to [DATE] revealed an order for Novolin insulin pen 100 unit/ml. Novolin 10 units subcutaneous. Administer only if blood sugar is greater than 300. Observation on [DATE] at 11:29 AM revealed the 200-hall nurse's medication cart had a pen of Novolin insulin pen 100 unit/ml for Resident #175, had an opened date of [DATE]. The label revealed discard after 28 days. 2- Record review of Resident #17's Comprehensive MDS, dated [DATE], revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included type 2 diabetes mellitus, elevated blood pressure, and hyperlipidemia (too many lipids and fats in the blood). He had a BIMS score of 12 indicating his cognition was cognitively moderately impaired. Record review of Resident #17's physician's orders dated [DATE] revealed an order for Humalog U - 100 Insulin (insulin lispro) solution; 100 unit/ml; administer per sliding scale. If blood sugar is ,d+[DATE]=3 units, , d+[DATE]=4 units, ,d+[DATE]=5 units, ,d+[DATE]=7 units, ,d+[DATE]=9 units, ,d+[DATE]=11 units Observation on [DATE] at 11:29 AM revealed the 200-hall nurse's medication cart had a pen of Humalog U-100 insulin 100 unit/ml, for Resident #17, had an opened date of [DATE]. The label revealed discard after 28 days. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 11:41 AM, LVN F stated the 2 pens of insulin belong to Resident #175 and Resident #17 had an expired open date. LVN F stated she did not use any of the insulin pens in the morning. She stated she did not check the pens for expiration dates. LVN F stated the purpose of open dates was for expiration purposes because the insulin was only good for 28 days. She stated expired insulin would be ineffective. Interview on [DATE] at 1:15 PM, the DON stated the insulin flex pens, once opened, needed to be dated because each insulin pen had a 28 or 30 days shelf life and if not thrown out before that time the insulin could lose its effectiveness. The DON stated the Assistant DON and the DON were supposed to do random check of the medication carts for monitoring. Record review of the facility's policy titled Medication Storage, dated [DATE], revealed in part .12. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of per procedures for medications destruction, and reordered from the pharmacy, if a current order exists.

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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. 48560 Based on observations, interviews and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen: 1. The facility failed to ensure food items in the facility refrigerator, freezer and dry storage were covered and dated. 2. The facility failed to ensure [NAME] A used appropriate hair restraint in the kitchen. 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. Findings included: Observation in facility's walk-in refrigerator on 05/21/24 at 9:31 AM revealed a packet of hot dog did not had an expiration date on them. Observation in facility's dry storage on 5/21/24 at 9:36 AM revealed a packet of tortilla in plastic bag did not had used-by date and a packet of cornflakes that was left open without an use-by date marked on it. Observation in facility's freezer on 5/21/24 at 9:32 AM revealed a packet of bread did not had an expiration date. Observation of lunch meal service on 5/22/24 at 12:11 PM revealed that [NAME] A did not wore his hair restraint properly. [NAME] A had half of his hair tied in a bun which was tucked in the hair restraint while the other half of the hair was not restrained under the hair restraint and left loose. Observed [NAME] A perform tasks in the kitchen prep area that included handling washed utensils with improper hair restraint. In an interview with Dietary Manager on 5/22/24 at 12:21 PM revealed all the cooks and dietary aide , including herself , were responsible for dating and covering food items in the kitchen. The food items should be dated with expiration date for all unopened items and use by date for opened items. She stated it was important to date all food items in the kitchen; so that older items can be used first and decrease the risk of any food borne illness. She stated that per facility policy, they need to follow all state, federal and US Food code guidelines for dating and storing food items in the kitchen. She stated it was her expectation that all staff entering the kitchen prep area including cooking, serving, and handling food item should always wear appropriate hair restraint such that all hair were covered. She stated that hair restraints were a part of the uniform in the kitchen. She stated failure to wear appropriate hair or beard restraint may lead to food safety issues including food borne illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with [NAME] A on 05/22/24 at 12:44 PM revealed he has been working in the facility for about 8 months. [NAME] A stated he had long , frizzy hair and some hair could be left out while wearing hair restraint. He stated he knew all hair needed to be secured appropriately to prevent any hair from getting into resident's food and the possibility of contacting food borne illness. He stated that cooks and dietary aide were responsible for dating and covering food items. He stated that all foods should be marked with an expiry date in the facility kithcen. He stated if the facility failed to label or date food items, they would not know how long the food items had been in the kitchen and can lead to compromised food safety for the residents. Record Review of the Facility's policy titled Food storage, revised June 2019, reflected To ensure that all foods served by the facility is of good quality for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines. 1. Dry Storage rooms d. To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated. 2. Refrigerators. d. Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage . Record Review of the Facility's policy titled Employee sanitation, dated October 2018, reflected .b. Hairnets, headbands, caps, beard coverings or other effective hair restraints must be worn to keep hair from food and food-contact surfaces . Review of the Food and Drug Administration Food Code, dated 2022, reflected, .3-302.12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food, or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food 3-305.11 Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety

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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** 42971 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 one of five residents (Resident #24) observed for infection control. Facility failed to ensure CNA D performed hand hygiene while providing incontinence care to Resident # 24. This failure could place the residents at risk for infection. Findings include: A record review of Resident #24's Quarterly MDS assessment, dated 04/30/2024, reflected Resident #24 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included type 2 diabetes mellitus, need for assistance with personal care, and dementia (condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain). Resident #24 had a BIMS of 07 which indicated Resident #24's cognition was severely impaired. Resident#24 required extensive assistance of two-person physical assistance with toilet use and personal hygiene. In an observation on 05/22/24 at 9:58 AM revealed CNA D and CNA E entered Resident #24's room to provide incontinence care. Both CNAs washed hands and put the gloves on their hands hands, CNA D cleaned the front pubic area. The resident was assisted onto her side revealing she had a medium bowel movement. CNA D discarded the dirty gloves, without hand hygiene she donned clean gloves. CNA E held resident and CNA D cleaned the resident's buttocks area using several wipes. CNA D, without changing gloves, she placed a clean brief under resident. Both CNAs repositioned the resident back on her back. Both CNAs gathered the dirty clothes and trash, removed their gloves, and washed hands. In an interview on 05/22/24 at 10:14 AM, CNA D stated she was to wash hands before and after care. CNA D also stated she was supposed to change gloves and complete hand hygiene after removing the dirty gloves. CNA D stated she did not complete hand hygiene or change gloves after cleaning the resident because she was nervous. CNA D stated she was supposed to change gloves and complete hand hygiene to prevent the spread of infection. In an interview on 05/22/24 at 01:15 PM with the DON she stated during incontinent care the staff were to complete hand hygiene before and after care. The DON also stated in between care CNA was to complete hand hygiene and change gloves because her hands were considered dirty after cleaning the resident. The DON stated the staff were to complete hand hygiene during care to prevent the spread of infection. Record review of the facility policy dated 12/1/2018, titled Hand Washing reflected, . it is the policy of this home that hand hygiene is the primary means to prevent the spread of infection. Procedures: . Employees must wash their hands for at least twenty seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: . After removing gloves .