STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676120	A. Building B. Wing	06/05/2025

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to ensure the resident had a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely for two of five shower rooms (shower rooms on 100 and 200 halls), 4 of 4 linen storage areas (3 blue carts (100, 200, and 300 halls) and 1 linens closet) reviewed for environment and 16 of 18 residents (Resident #14, Resident #19, Resident #58, and Resident #65) and 12 confidential residents reviewed for clean linens which included towels, and sheets. 1. The facility failed to ensure the shower rooms were cleaned throughout the day, kept orderly, and maintained in a sanitary and comfortable condition for resident use. 2. The facility failed to ensure there were clean washcloths for Residents #19, #58, and #65 on 06/04/25 and 06/05/25 for bathing. 3. The facility failed to provide clean bed linens for Resident #14's bed on 6/3/25 and 6/4/25. The failures could place residents at risk of exposure to infectious diseases and other unsanitary health hazards. Findings include: 1. (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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	While in an observation and interview for laundry on 06/04/2025 at 01:25 PM with Housekeeping Supervisor the shower rooms were observed. It was revealed that the 100 and 200 hall shower rooms had orange and pink residue along the grout lines of the bottom perimeter of the tiled shower, on areas of the tile wall and floor of the shower. Hall 100 shower room also had a brown residue on left side of the upper wall of shower. Hall 200 shower room also had light black areas of grout where the floor and wall met. When observed, Housekeeping Supervisor stated that the expectations were for the shower rooms to be cleaned daily. She stated that when she did competency checks of housekeepers work, she did not look down in the shower at the walls and floors. She stated that she had not noticed the orange, pink, black residue in the shower until it was pointed out. She stated that the showers were not cleaned to the standard that she wanted. In an observation and interview of hall 200 shower room on 06/04/2025 at 01:45 PM with the Administrator, he observed the orange, pink, and black residue on the left and back side of the shower wall and floor. He stated that the cleaning was not up to his standards and that the shower needed to be power washed. In an observation and interview on 06/05/2025 at 09:18 AM with Housekeeper L revealed she was responsible for cleaning on the 200 hall and odd rooms on the 300 hall, and the dining room after breakfast and lunch. She stated that she had cleaned the hall 200 shower on 06/04/2025. She observed the 200 hall shower which revealed an orange and pink residue. She stated that when she sprayed the Micro-kill all the residue usually came off without her having to scrub the walls. She stated that she did know why the orange and pink residue observed in the shower did not come out. She stated that the cleaning solution she used was called Medline Micro-kill. She observed the shower room on the 200 hall and stated residue came off once she sprayed it. Housekeeper L demonstrated and explained how she cleaned the shower room. She stated that she sprayed everything in the shower room which included the faucet, entire toilet, shower handrails, shower knobs, all shower walls and the shower floor with Micro-kill. After she sprayed the Micro-kill, she would let it sit and while sitting she would mop from inside the shower room on her way out to the 200 hall. She stated after she mopped, she went back in the shower room and sprayed the shower with water and wiped everywhere she sprayed with a rag. Housekeeper L stated that she wiped the shower wall from top to bottom. She stated she was out of green pads to scrub the showers. Observation of a bottle of Medline Micro-Kill R2 that Housekeeper L stated that she used. Housekeeper L stated that the risk of not properly cleaning was that residents could get sick. In an observation and interview on 06/05/2025 at 09:37 AM with Housekeeper M revealed she was responsible for cleaning all areas. She observed the 100 shower room which revealed a circular 2 to 4 inch brown stain on the back of the shower wall. She stated that the shower room had already been cleaned and stated that the brown stain appeared to be poop. She stated that she worked the days that each housekeeper had off. She stated that she worked opposite of the normal housekeepers. She stated that she would take the Micro-kill to spray handles and everything in the shower room. She stated after she sprayed, she swept then wiped down everywhere she sprayed with her towel. She stated that on the current week she cleaned the 200 hall on 06/01/2025 and 100 hall on 06/04/2025 and today. She stated that there had not ever been scrubbers at the facility to clean the shower rooms since she started working. She stated that she was not accustomed to cleaning a shower room with just a rag. She stated when she asked supervisor about scrubbers, she was told that the facility did not use scrubbers. Housekeeper M stated that the risk to residents for not properly cleaning could mess with the residents breathing. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/05/2025 at 10:15 AM with CNA E revealed that the housekeepers did not clean the shower rooms. She stated that it was the aides that cleaned the shower room. She stated that they were only cleaning because State was in the building. She stated that the housekeepers were acting because they did not usually do all that cleaning that they were doing. 2. Record review of Resident #19's Quarterly MDS dated [DATE], reflected she was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #19 had intact cognition and a BIMS score of 15. She used a motorized wheelchair to get around in the facility. Resident #19 had the following diagnoses which included Dementia (lose of cognition), Parkinson's disease (movement affected), and Other specified arthritis (pain, stiffness, and inflammation in the joints). In an interview with Resident #19 on 06/04/2025 at 09:05 AM, she stated that she was bathed regularly. She stated that most times the facility had towels but when they did not, she used her pillowcase to bathe. She stated that she was told that laundry was backed up. Record review of Resident #58's Quarterly MDS dated [DATE], reflected a [AGE] year-old who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #58 had intact cognition and a BIMS score of 15. She used a wheelchair to get around in the facility. Resident #58 had diagnoses which included Vascular dementia (disruption of blood flow to the brain), Need for assistance with personal care, Polymyalgia rheumatica (pain and stiffness in shoulders, neck, and hips), Unspecified inflammatory spondylopathy (inflammation that affect spine and joints causing pain and stiffness), Other recurrent depressive disorders (high-function depression (persistent sadness and loss of interest). In an interview with Resident #58 on 06/03/2025 at 11:53 AM, it was revealed that the facility was always out of washcloth towels. She stated that she had to use a big towel for her washcloths on numerous occasions. She stated that when she asked about it, she was told by staff that the towels just disappeared. Record review of Resident #65's Quarterly MDS dated [DATE], reflected an [AGE] year-old who was admitted to the facility on [DATE]. Resident #65 had intact cognition and a BIMS score of 13. She used a wheelchair to get around in the facility. Resident #65 had diagnoses of the which included the following, Unspecified dementia (loss of memory, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety) (undetermined dementia with lack of behavior disturbance), Other abnormalities of gait (walking or running) and mobility (ability to move freely and easily), Unspecified lack of coordination (inability to coordinate voluntary muscle movements), Other intervertebral disc degeneration (discs that cushion the backbone in the spine begin to breakdown). In an interview with Resident #65 on 06/03/2025 at 11:50AM, it was revealed that the facility did not always have washcloths for her when it was time for showers. Resident #65 stated that when she did not have a washcloth for a shower, she would use a large towel. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a confidential group interview on 06/04/2025 at 11:03 AM with 12 residents, the 12 residents had concerns with availability and cleanliness of washcloths. Interview revealed in the confidential group stated there are not always available washcloths when it was time for showers. Residents stated that they would use one of the big towels or pillowcases to bathe. It was also revealed that bed linens were not being changed with clean sheets after showers. In an interview and observation on 06/04/2025 at 12:27 PM with Laundry Aide S, she revealed that she was told and made aware by residents that there were not towels for everyone. She stated that on 06/04/25 she had not folded many washcloths. She stated that any towels that were not in the laundry room were on a blue cart in the hallways which was not many. She stated that she had almost completed all laundry and she had not washed or folded many washcloths. She stated that there had been issues with not enough towels for a little while. She also stated that there was a time when the towels were replenished then the towels started dwindling away. She also stated that any extra laundry that the facility had was in the laundry/housekeeping supervisor's office. The laundry room was observed with no washcloths on the table with the clean linen. There were approximately 7 large bath towels observed on the folding table in the laundry room. In an interview with the Housekeeping Supervisor on 06/04/2025 at 01:17 PM, she stated that there were not many of the washcloth towels because the washcloths were being thrown away by the residents. She stated that there had not been a shortage with towels. She also stated that she could have had washcloth and big towels completely stocked and towards the end of the day there would not be any towels left. She stated that she kept the overstock supply of linens in her office. She stated once the linens in her office ran short, she gave the list of supplies that needed to be ordered to the Medical Records department to order what was needed. She stated that she pulled the last of the towels out of her office on 05/30/2025. She also stated that an order was completed on 06/04/2025. She stated that she ordered towels at least every two weeks. She stated that she tried to keep her office stocked and did not have problems with having towels and linens ordered. In an interview and observation on 06/04/2025 at 01:24 PM with the Housekeeping Supervisor there were no clean washcloths and 2 clean large towels on the 200 hall laundry cart, no clean washcloths and no clean large dry towels on the 100 hall laundry cart, approximately 9 clean big towels and approximately 6 clean washcloths in the laundry storage room, and approximately 7 clean big towels on the 300 hall laundry cart. She stated that she did not know where the washcloth towels were during the observation of linens. She stated that during the walk around observation that there were not may washcloths in the areas observed. Record review on 06/05/25 of supplies order titled, Medline Packing List, revealed an order date of 05/07/2025 with a quantity of 10 packs with 12 washcloths each. The order on 05/07/2025 was the last order of washcloths. 3. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #14's MDS reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Resident #14 had little to no cognitive deficit and had a BIMS score of 13. She used a wheelchair to get around in the facility. She required partial to moderate assistance with most ADLs. Resident #14 had the following active diagnoses: Non-Alzheimer's Dementia (a progressive and irreversible neurodegenerative disease), Depression (a serious mood disorder characterized by persistent feeling of sadness, loss of interest or pleasure in activities and changes in thinking, sleeping, and acting), Vascular Dementia (memory loss in older adults) and chronic kidney disease(longstanding disease of the kidneys leading to renal failure). Observation of Resident #14's bedroom on 06/03/25 at 10:30 AM revealed the fitted sheet on her bed had a circular 3 to 4 inch grayish black with little black specks stain close to her footboard. Resident #14 was not in her room at the time of the observation. Observation of Resident #14's bedroom on 06/04/25 at 08:58 revealed the fitted sheet on her bed had the same stain from the day before and did not appear to have been changed. Interview with CNA E on 6/3/25 at 9:17am revealed she was working Resident #14's hall this morning and had not changed her sheets. She acknowledged she typically changed sheets when they were dirty like Resident #14's sheets. She stated sheets needed to be changed every shift if they were dirty like the sheets on Resident #14's bed. She had no idea when they last changed Resident #14's sheets, but they should have been changed on her last shower day. Resident #14's showers were on Tuesdays, Thursdays, and Saturdays on the 6am to 2pm shifts. She stated she had not worked Resident #14's hall yesterday and did not know if she had gotten a shower yesterday. Interview with CNA O on 6/3/25 at 9:23am revealed Resident #14's sheets should have been changed yesterday regardless of if she had a shower or not. She did not work the hall yesterday and did not know why Resident #14's sheets were not changed. She stated sheets were changed every shower day regardless of if they were soiled or not. If she would have seen them dirty, then she would have changed them. She was not working Resident #14's portion of that hall today. The risk to the resident of not changing her dirty sheet would be infection, sore breakdown, and rashes. Interview and observation with Resident #14 on 06/04/25 at 01:55 PM revealed she had not had a shower this week and her sheets were usually changed on shower days. She stated her shower day was yesterday and she did not get a shower, or her sheets changed. She stated they told her they would shower her yesterday, but no one ever came to shower her. She stated she did not enjoy sleeping on dirty sheets. She states she did not remember how dirty her sheets were but was appreciative they changed them. It was observed the resident's sheets on her bed had been changed. Interview with LVN A on 6/4/25 2:47pm revealed he made sure residents got showers and their sheets changed on every shift when they were due. He had not heard about Resident #14 rejecting her shower or sheet changes. He assessed sheets every two hours during his shift and ensured CNAs changed dirty sheets. He defined dirty sheets as wet or having stains. He had not observed Resident #14's sheets dirty. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with CNA P on 6/5/25 at 8:27am revealed she did not know the resident, but CNAs typically change sheets on shower days, which would be 3 times per week or if the bed was soiled. Most of the time they would have enough towels and linens but there were times, about twice a month, they didn't have enough linens and towels. The risk to the resident was they may not be able to shower them. She stated the worst shortage was towels and wash cloths. Interview with CNA Q on 6/5/25 at 8:35am revealed she changed sheets for residents on bath days and if they were incontinent, specifically if there was a stain or spot on the sheets. Most of the time they would have enough linen to change beds unless the washer was down. Sometimes they have had to borrow towels from other halls because they could not find any. If she could not find any towels, she would find the Housekeeping Supervisor and request more towels, as she had some in her office. The Housekeeping Supervisor had never told them there were no more towels. The risk to the resident if there were not enough linens and towels would be they could not get changed and would be lying in a dirty bed. Interview with LVN B on 6/5/25 at 8:55am revealed when sheets were soiled, she would make sure they would change them during her shift. If the sheets were wet, stained or if there was food on them, she would request staff to change the sheets. She stated ideally sheets should be changed every shift in her opinion. Sometimes there had been issues with not having enough towels or linens and it happened a couple times per month. The risk to the resident of not getting sheets changed were skin breakdown and possible infection if they had any wounds. If her resident had sheets with a circle of dirt, she would request for them to be changed. Observation on 6/5/25 at 9:01am of Resident 14's bed was stripped and had no sheets. The mattress was exposed to the air without any linen. Interview with LVN I on 6/5/25 at 9:15am revealed she was working Resident #14's hall for the past two days. She stated Resident #14 should have had her sheets changed on her bath days. If she declines a bath, her sheets should still have gotten changed. She stated she did not know when Resident #14's sheets had been last changed and had not known she had dirty sheets. She stated she would talk to the CNAs about changing Resident #14's sheets more frequently. The risk to the resident of not changing sheets would be possible infection. The sheets needed to be changed regardless of if they had a stain or dirt on them. She stated at times they run out of linens and must go to the laundry room to get them and it's usually once or twice per week. Interview with the DON on 6/5/25 at 10:56am revealed bed sheets were supposed to be changed on shower days but if they were soiled, they need to be changed sooner. Soiled was described as wet or dirty. She acknowledged Resident #14 tended to have dirty sheets because she refused to wear socks or shoes while in her wheelchair amd her feet would get dirty. She stated Resident #14's sheets should have been changed daily. The risk to the resident of having had dirty sheets was skin breakdown. Interview with the Administrator on 6/5/25 at 12:42pm revealed his expectation was sheets be changed as much as needed. He noted staff should have made rounds every 2 hours and should have checked to see whether sheets needed to be changed. Moreover, sheets should have been changed on the shower days, unless residents did not want them changed. He had heard on occasion the facility did not have linens, but they always find linens. When he heard they didn't have linens he would do a sweep of the facility to locate them, wash them if needed and would put more out if needed. He had never denied an order for linens. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility's policy titled Statement of Resident Rights, revision date of 12/1/2018, reflected the following: 3. Safe, decent, and clean conditions. A safe, clean, homelike environment policy was requested via email on 06/05/25 at 9:32 AM, but the policy was not received by exit of survey on 06/05/25 at 3:15pm.

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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 3 (Residents #227, #46, #32) of 18 residents reviewed for comprehensive care plans. 1. The facility failed to create a care plan that reflected Resident #227's preference for only female staff to provide her personal care. 2. The facility failed to create a care plan that reflected Resident #46's preference for only female staff except for CNA T (a male CNA) to care for her. 3. The facility failed to create a care plan that reflected Resident #32's highly impaired hearing, vision, and aphasia. These failures place residents at risk of not receiving care and services related to their identified needs to maintain or reach their highest practicable physical, mental, and psychosocial well-being. Findings Include: 1.Review of Resident #227 admission Minimum Data Set (MDS) Assessment, dated 5/13/25, reflected she was a [AGE] year-old female with an admission date of 5/6/25. Resident #227 had no impairment to her cognition and had a BIMS score of 15. Resident #227 needed substantial assistance with transfers, toileting, and showering. Resident #227 was frequently incontinent from bowel and bladder. She had the following diagnosis: Diabetes (a group of diseases that result in too much sugar in the blood), Malnutrition, Depression (a persistent mood disorder characterized by loss of interest or pleasure in activities and prolonged sad moods), Metabolic Encephalopathy (a brain disorder characterized by changes in mental status or consciousness due to an underlying metabolic imbalance) and muscle weakness. Interview with Resident #227 on 06/03/25 at 10:13am revealed she had told staff several times she did not want male caretakers providing her incontinent care, but she was getting pressured the weekend of 5/31/25 to get changed by a male staff. Resident #227 stated she had told multiple staff of her preference. Review of Resident #227's care plan dated 5/8/25 did not reveal the resident's preference for female caretakers during incontinent care, showers and baths. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LVN A on 6/4/25 at 2:47pm revealed he was informed by Resident #227 she preferred a female caretaker to change her for incontinent care. He stated he got a female CNA to provide her incontinent care that day. He stated he was told by Resident #227 about 2 weeks ago about her preference for female caretakers. He stated he never told the ADON or DON about her preference because it occurred during the weekend when they were not there. The risk to the resident of everyone not knowing her preference for caretakers was delayed incontinent care. Interview with MA C on 6/5/25 at 9:03am revealed she worked Resident #227's hall frequently and she was not aware Resident #227 did not want male aides providing her personal care likes baths and incontinent care. Interview with LVN I on 6/5/25 at 10:00 am revealed she was familiar with Resident #227 but was not aware of Resident #227's preference for female caretakers. 2. Record review of Resident #46's Quarterly MDS, dated [DATE], reflected she was a [AGE] year-old female, admitted to the facility on [DATE], with the diagnoses of dementia (loss of cognition), depression (persistent feelings of sadness) with a BIMS score of 6 (severely impaired cognition). In an interview on 06/03/25 at 9:58 AM with Resident #46 and her family member, Resident #46 stated that she did not feel comfortable with male aides, with the exception of CNA T, and was not sure if it was care planned. Her family member stated that on Saturday (05/31/25) and Sunday (06/01/25) there were male aides assigned to her and the family member and Resident #46 had to tell them that Resident #46 preferred female aides only. They stated that the male aides found a female from another hall to perform incontinent care but it was frustrating that it happened two days in a row where they had to explain Resident #46 did not feel comfortable with men in her room and preferred to have females provide incontinent care, with the exception of CNA T. Resident #46 stated that CNA T was the only male aide she felt comfortable with and would prefer either CNA T or females only in her room. In an interview on 06/04/25 at 2:39 PM with CNA E, she stated that Resident #46 preferred females to take care of her. She stated that Resident #46 told her she didn't want any men in her room. She stated that she informed the nurse, and it was well known by staff. In an interview on 06/04/25 at 7:04 PM with LVN R, she stated that Resident #46 had told her in the past that she did not want any male caregivers to take care of her except for one male aide, CNA T. LVN R stated at the start of her shift, she informed Resident #46 who was working on that shift; and if there was a male assigned to her, LVN R told Resident #46 which female aide would be taking care of her instead to accommodate her preference and ensure she felt comfortable. She stated that the MDS Nurse was responsible for updating care plans and was not aware that Resident #46's preference for female caregivers was not care planned. LVN R stated it was important to care plan a resident's preference for male or female caregivers so that staff knew the resident's wishes. In an interview on 06/04/25 at 7:36 PM with LVN S, he stated that Resident #46 did seem to have anxiety but he was not aware of any preferences she had for CNA T or female caregivers or if it was care planned. He stated Resident #46 seemed to be comfortable with him because when he went in to check on her and let her know he was taking care of her during the evening shifts, she said things like thank god you are here or thank god [CNA T] is here. He stated it would be important to care plan a resident's preferences for female aides because it ensured staff knew what a resident needed and preferred. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/05/25 at 9:35 AM with the Social Worker, she stated she was not sure if Resident #46 had a preference for male or female caregivers and it was important to care plan if she preferred female aides only and if there were exceptions to that preference because residents had a right to have their preferences honored, especially with incontinent care. 3. Record review of Resident #32's Comprehensive MDS, dated [DATE], reflected he was an [AGE] year-old male, admitted to the facility on [DATE] with the diagnoses of aphasia (loss of ability to understand or express speech) due to stoke, highly impaired hearing, moderately impaired vision, and unclear speech with a BIMS score of 00 (severely impaired cognition). In an observation on 06/03/25 at 10:17 PM of Resident #32 revealed he was seated in a wheelchair taking out hearing aids and was not responsive to attempt at interview. Observation of sign above Resident #32's bed revealed take resident hearing aides out before showers. Record review of Resident #32's care plan, dated last revised 06/03/25, revealed no indication regarding his hearing or speech (related to aphasia), or vision. In an interview on 06/04/2025 at 8:58 AM with Resident #32's Responsible Party she stated that Resident #32 was blind in one eye and had extreme hearing difficulty and aphasia due to a stroke. She stated she was not able to recall if there had been care plan meetings that discussed his aphasia, hearing, and vision status, and he admitted to the facility for rehabilitation services following the stroke, with a goal to discharge home. In an interview on 06/04/25 at 2:39 PM with CNA E, she stated that Resident #32 was very hard of hearing and she had to get up to his left ear and speak loudly for him to hear and he did not like to wear his hearing aid. She stated she did not think he had much difficulty seeing. In an interview on 06/04/25 at 1:26 PM with MA D she stated that Resident #32 had difficulty hearing and was not sure if he had vision issues. In an interview on 06/04/25 at 7:36 PM with LVN S, he stated Resident #32 had highly impaired hearing and had aphasia and was not sure if it was care planned. He stated he thought Resident #32 might have a vision impairment, but he was not sure. He stated that it was important to care plan hearing, vision, or communication difficulties to ensure staff were able communicate with the resident and meet their needs. In an interview on 06/05/25 at 9:35 AM with the Social Worker revealed Resident #32 had a stroke and admitted to the facility to rehabilitate and eventually discharge back home. She stated he had a severe hearing issue and had headphones that had amplifiers and a hearing aid. She stated the resident's hearing and vision issues should be care planned because caregivers needed to know how to be able to communicate with Resident #32. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676120	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/05/25 at 10:08 AM with the Regional Reimbursement Consultant, she stated other regional personnel and the nursing team were responsible for updating the care plans. She stated the facility hired a full time MDS Nurse about 2 weeks ago and she was in-training. She stated she was on-site several days a week and was responsible for annual and quarterly care plans and updated care plans when she was offsite; and the DON helped with acute care plans and any of the clinical team had the ability to update care plans, but they usually reached out to her to update the care plans. She stated she received updates by any of the clinical nursing or clinical regional team or the Administrator via email, phone, or when she was on-site when updates to resident care plans were needed or if there were questions on how to care plan something. She stated she was not sure if Resident #32 had hearing issues. She reviewed his progress notes and his Comprehensive MDS and stated he had highly impaired hearing, moderately impaired vision, and aphasia due to a stroke. She stated that his hearing, vision, and aphasia was not care planned and it was important to care plan those issues to ensure staff could communicate effectively with the resident. She stated she was not familiar with Resident #46 and was not aware she preferred female care givers for incontinent care. She stated she was not aware that Resident #227's preference for female care givers and it was not care planned. She stated if a resident preferred a specific gender of caretaker it should be care planned. She stated it was important to care plan a resident's preference for female caregivers and if there were exceptions to that preference because knowing a resident's preferences ensured staff were aware and the resident's rights were honored. In an interview on 06/05/25 at 10:55 AM with the DON, she stated that nurses had the ability to update the care plan and it generally was updated by the Reimbursement Consultant who was in the process of training a newly hired full time MDS Coordinator for the facility. She stated she did not know Resident #32's hearing, vision, and aphasia difficulties were not care planned and it was important because it ensured staff knew he was hard of hearing and guided their plan of care. The DON stated that she was aware that Resident #227 preferred female caregivers only and Resident #46 preferred female aides except for CNA T and she ensured staff were aware by word of mouth and during shift change. She stated a resident's preference for female caregivers should be care planned so that staff were aware and had a place to look and see what the resident preferences were. She stated it was her and the MDS Nurse Coordinator, which had been covered by the Regional Reimbursement Consultant, to ensure care plans were updated. Interview with the Administrator on 6/5/25 at 12:42pm revealed he was not aware Resident #227 only wanted female caretakers. He stated request like those were usually put in the resident's care plan or the Nursing Book at the nursing station. He was unsure if Resident #227's preference was listed on her care plan or in the Nursing Book. He stated it was important to honor the resident's wishes by providing her care based on her preference. Review of the Facility's policy Care Plan - Resident effective date 12/2018 reflected .12. Resident Care Plan Documentation and use of the Plan, a. The resident care plan is used to plan and assign care for all disciplines .c. The resident care plan must be kept current at all times .

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	676120	A. Building B. Wing	06/05/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a therapeutic diet when ordered by the physician to maintain adequate nutritional status, to the extent possible to maintain acceptable parameters of nutritional status for 1 of 18 residents (Resident #227) reviewed for nutrition: The facility did not ensure Resident #227's diet was consistent with physician's order on 5/8/25 for Diabetic Diet. This failure could place the resident at risk for weight loss and further decline in health. Findings included: Review of Resident #227 admission Minimum Data Set (MDS) Assessment, dated 5/13/25, reflected she was a [AGE] year-old female with an admission date of 5/6/25. Resident #227 had no impairment to her cognition and had a BIMS score of 15. The resident was to have a therapeutic diet while a resident at the facility. She had the following diagnoses: Diabetes (a group of diseases that result in too much sugar in the blood), Malnutrition, Anemia (a condition marked by a deficiency of red blood cells or hemoglobin in the blood), Gastroesophageal Reflux Disease (a condition in which stomach contents flow back up into the esophagus, causing irritation and discomfort), and muscle weakness. Review of the active physician's order dated 5/8/25 for Resident #227 reflected Diet - NSOT diet, Diabetic, Regular texture, Thin Liquids, 1500ml fluid restriction. Lactose intolerant. Review of Resident #227's Summit Baseline Careplan dated 5/7/25 reflected the diet type was NSOT. Review of Resident #227's Care Plan dated 5/8/25 reflected .Problem Start Date: 06/03/2025 Category: Dietary Resident is at nutritional/weight variance risk r/t therapeutic diet, lymphedema, diuretic therapy, kidney disease and diabetes .Approach Start Date: 06/03/2025 Diet as ordered Created: 06/03/2025 . Review of Resident #227's Medical Nutrition Therapy Assessment dated 6/2/25 reflected .Diet (Type, texture, fluids) NSOT diabetic diet, regular texture, thin liquids. 1500 ml fluid restriction . Review of Resident #227's lunch meal ticket on 6/3/25 reflected .Diet: Regular, Texture: Regular, Diet Other NSOT .Allergies: Milk . Interview with Resident #227 on 6/3/25 at 10:13am revealed she was lactose intolerant, was diabetic, had gout and the food she was receiving was not matching her medical needs , she had gotten a lot of carbs on her trays. Resident #227 stated she had spoken to the Dietician the day before and was hopeful that her meals would be corrected. Observation of Resident #227's lunch tray on 6/3/25 at 1:06pm reflected broccoli, a dinner roll, 1 piece of fried chicken, lettuce and tomato salad, Italian dressing, pineapples in juice, tea, water, butter and packets of sugar. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Dietician J on 6/4/25 at 11:25am revealed the Dietary Manager would initially meet with the residents during admission to obtain information about resident's food preferences. The Dietary Manager would then meet with residents as needed or quarterly to update preferences. She stated the facility did not have a diabetic diet, they had a therapeutic LCS diet. She stated there was no such thing as a diabetic diet at the facility. She stated the facility did not have a specific diet for lactose intolerance, but a restriction on a food or intolerances would be documented in a progress note in the EMR and on their tray ticket. Not all residents who were diabetic were on an LCS diet, unless it was indicated by a doctor, or the resident was experiencing negative effects from having had a regular diet. While reviewing Resident #227's EMR she reviewed the doctor's order on 5/8/25 where it indicated a diabetic diet and she stated that was not the proper verbiage for a restricted diet for someone with diabetes. If the doctor deemed it appropriate, then it would have been an LCS diet. She reviewed Resident #227's lunch ticket from 6/4/25 and stated in her opinion it was consistent with the physician order on 5/8/25 due to the facility not having a diabetic diet. She was not assigned to this facility and had not met with Resident #227. She stated a colleague of hers had met with that resident. Dieticians typically met with residents when there was a complaint or if there was a concern for weight loss. New admits were reviewed the next time the Dietician came to the facility. Dieticians could make a recommendation for diet change when they reviewed the new admits, but the doctor had to modify the order and accept the change. Interview with the DON on 6/4/25 at 12:00pm revealed the facility did not have a diabetic diet and called the doctor on behalf of Resident #227's since the order was incorrect and corrected the order to LCS diet. She clarified the resident had a milk and lactose allergy and had that corrected as well on her ticket and EMR. The DON stated she would also go speak to Resident #227 regarding her food preferences. Interview with the Manger for Nutritious Lifestyle on 6/4/25 at 2:09pm revealed she was the supervisor of the dieticians that go to the facility. She stated that the dieticians spent 16 to 24 hours per month at each facility, which was equivalent to 2-3 onsite visits per month. Dietician K was the dietician that visited the facility regularly. He was last at the facility on 6/2/25 at which time he assessed Resident #227 but did not assess her dietary needs in May 2025 . The facility had a 30-day window for dieticians to meet with new residents after they were admitted to the facility. The facility had the option to reach out to the Dietician at any time if they needed assistance with a resident. Dieticians did not have to approve a diet change and were not required to update dietary staff on diet changes. Most of the time, changes to diets happened internally without the dietician and the dietician would review the change at the next visit. Doctors had the final say on residents' diets. Interview with the Dietary Manager on 6/4/25 at1:35pm revealed she had met with Resident #227 when she first arrived at the facility to discusses food preferences. Resident #227 told her that she was allergic to milk. She was just notified earlier that morning about Resident #227's need for diabetic food. She was not notified prior to today of the resident's need for an LCS diet. She stated Resident #227 now had a LCS diet and lactose allergy listed on her ticket and in their system. She stated typically nursing notified her when there was a new order for a diet for a resident. Nursing would give her a copy of the order and she would enter it in the system. The risk to the resident of not having had the correct order was it could cause illness. (continued on next page)

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	676120	A. Building B. Wing	06/05/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 6/5/25 at 10:56am revealed their process for new admits was the nurse filled out a dietary form with the prescribed diet and it would be handed to the Dietary Manager. If nursing got an order to change a diet, they were supposed to print it and hand it to dietary. The person who received Resident #227's order should have clarified with the doctor what therapeutic diet he wanted because the facility did not have a Diabetic Diet. The dietician would review diet orders when they came to the facility and made recommendations of change if necessary. The Dietician was at the facility 3 times in May 2025 but had not met with Resident #227. The Dietician should be looking at orders and making recommendations and therefore should have caught the error on Resident #227's dietary order. She had the Dietary Manager speak to Resident #227 yesterday and it was corrected. The risk to the resident of not having had the correct diet was that that her blood sugar could have been elevated and could have affected her need for medications. Review of the facility's policy Diets Offered by the Facility dated 4/26/19 reflected .The following diets are available: Regular, No added Salt, LCS, Liberal Renal (kidney), Puree, mechanical soft. Procedure: 1. All diets must be ordered by the attending physician and recorded in the resident's medical record. 2. Nursing services will complete a Diet Order Form for all new admissions and diet changes and forward to Nutrition and Food service Department .3. Any order for diets other than those above or diet orders for as tolerated will be clarified by nursing prior to forwarding the Diet Order from to the Dietary Department .If a physician orders a special diet, nursing will consult with the physician to determine if one of the diets above can be substituted . Review of the Facility's policy Liberalized Diets dated 4/26/29 reflected .1. Nursing will clarify any diet that does not match the diets offered at the facility prior to forwarding the diet order form to the dietary Department. 2. Nursing will use the following to clarity the liberalized diet with the physician: If these diets are ordered .Diabetic .Obtain order for: Low Concentrated Sweets (LCS) .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents who require dialysis receive such services, consistent with professional standards of practice, for one (Residents #177) of one resident reviewed for dialysis. The facility nursing staff failed to document and assess Resident #177's returning vital signs, access site, and mental status after Resident #177 returned from dialysis treatment on 05/27/25, 05/31/25, and 06/03/25. This failure places residents in the facility who received dialysis at risk of not receiving proper care and coordination of care. Findings included: Record review of Resident #177's Comprehensive MDS, dated [DATE], reflected she was a [AGE] year-old female admitted to the facility admitted on [DATE] with the diagnoses of anemia (low iron), kidney disease, heart failure, and diabetes (high blood sugar) with a BIMS score of 15 (intact cognition). Resident #177 required dialysis services. Record review of Resident #177's care plan, dated 06/03/25 reflected The resident is on dialysis due to Acute kidney failure . on Tuesdays and Saturdays at 9:30 AM. In an interview on 06/03/25 at 1:43 PM with Resident #177 she stated she just got back from dialysis. She stated there was an issue with transportation to dialysis once, when she first admitted to the facility, and there had been no problems since then. She stated she had no concerns regarding her dialysis. She stated she planned to discharge home soon. Review of Resident #177's Dialysis Communication Record Binder reflected the following: Dialysis Communication Record Form dated 05/27/25 revealed Resident #177's facility pre-dialysis and post-dialysis section was not completed by the facility nurse for vital signs, access site, dressing, and if there was any change of condition; the dialysis nurse completed their section. Dialysis Communication Record Form dated 05/31/25 revealed Resident #177's facility pre-dialysis vital signs were taken, the access site was assessed, and the medication list by LVN R; the dialysis nurse completed their section, and the post-dialysis section was not completed by the facility nurse for vital signs, access site, dressing, and if there were new orders. Dialysis Communication Record Form dated 06/03/25 revealed Resident #177's facility pre-dialysis vital signs were taken, the access site assessed, and the medication list and was not signed by a facility nurse; the dialysis nurse completed their section, and the post-dialysis section was not completed by the facility nurse for vital signs, access site, dressing, and if there were new orders. Record review of Resident #177's vitals from 05/22/25-06/03/25 reflected the following on dialysis days: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676120	A. Building B. Wing	06/05/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-vitals dated 05/27/25 at 7:27 AM: blood pressure 108/71; pulse 98 bpm by MA D -vitals dated 06/03/25 at 7 PM: pulse 78 bpm by LVN U Record review of Resident #177's Medication Administration History from 05/05/25 to 06/05/25 reflected the following order: metoprolol tartrate 25 mg tablet for hypertension twice a day with special instructions of per order from dialysis please hold metoprolol before dialysis ., and monitoring of pulse and blood pressure at 7 AM and 7 PM, start dated 01/27/25 and discontinue date of 06/03/25. Review of blood pressure and pulse on the following dialysis days reflected the following: 05/27/25: Scheduled time 7 AM: Not Administered: On Hold .Comment: dialysis charted at 7:28 AM by MA D Scheduled time 7 PM: Not Administered: Other . Comment: dialysis charted at 11:51 AM by MA D 05/31/25: Scheduled time 7 AM: Not Administered: Refused charted at 7:27 AM by MA X Scheduled time 7 PM: Not Administered: Refused charted at 6:26 PM by MA X 06/03/25: Scheduled time 7 AM: Not Administered: Other .Comment: dialysis charted at 6:15 AM by MA D Scheduled time 7 PM: Late Administration: Charted late .Comment: adm on time .Pulse: 78 .Blood Pressure: 121/58 charted at 8:52 PM by LVN U. There were no Progress Notes about assessment of Resident #177's dialysis pre or post assessment by nursing for the date range of 05/22/25-06/03/25. In an interview on 06/04/25 at 1:26 PM with MA D, she stated that Resident #177 was on dialysis services and she completed vital signs before she left for dialysis. She stated that nurses assessed the resident when she returned. In an interview on 06/05/25 at 10:55 AM with the DON she stated that LVNs should be completing the vitals section of the Dialysis Communication Sheets before and upon return of the resident to dialysis and did not know they were not completed upon Resident #177's return from dialysis. She stated she was going to in-service staff immediately. She stated that it was important for the nurses to complete the return section of the dialysis communication record form to ensure the resident was doing well post-dialysis. (continued on next page)

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	676120	A. Building B. Wing	06/05/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/05/25 at 12:45 PM with LVN B she stated she worked on 06/03/25 during the 6 AM -2 PM shift and completed the dialysis communication record top portion for Resident #177. She stated she checked Resident #177 vitals and filled out the top portion of the form before Resident #177 left to dialysis and then when Resident #177 returned she checked the sheet for any new orders or changes, but she did not know if she was supposed to check Resident #177's vitals when she returned from dialysis. In an interview on 06/05/25 at 1:21 PM with the Administrator he stated he expected staff to follow their policy regarding the dialysis communication record sheets and the DON was going to in-service staff on the policy and procedures. Record review of the facility's policy and procedure titled Dialysis-General Guidelines and Management, dated December 2018, reflected: It is the policy of this home that dialysis residents will receive dialysis service as per physician orders and will be monitored accordingly . Potential Complications After Hemodialysis :(a treatment that cleans the blood) Disequilibrium phenomenon (loss of balance) results when excess solutes (urea) are cleared from the blood more rapidly than they can diffuse from the body's cells into the vascular compartment . Nursing Implications: 1. Monitor blood pressure and pulse . Potential Complications After Hemodialysis: Blood Loss/Hemorrhage . Nursing Implications: 1. Check access site immediately when resident returns. 2. Check vitals (B/P in arm opposite of access site) .

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	676120	A. Building B. Wing	06/05/2025

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being for one of two (Resident #43) reviewed for behavioral health services. The facility failed to ensure Resident #43 received his ongoing psychiatric services. Resident #43's last psychiatric appointment provided was on 01/29/25. This failure could place residents at risk for not receiving behavioral health services and a decline in quality of life. Findings Included: Record review of Resident #43 quarterly MDS assessment dated [DATE] reflected a [AGE] year-old male with an admission date of 12/01/19. Resident #43 had a BIMS of 15 which indicated he was cognitively intact. There were no behaviors, signs of delusions or rejection of care noted on the assessment. Resident #43 had active diagnoses which included anxiety, depression, schizophrenia which included schizoaffective disorder and post-traumatic stress disorder. Record review of Resident #43's MD's progress note dated 01/03/24 reflected, .Has multiple psychiatric problems including anxiety, depression, schizoaffective disorder, post traumatic disorder, is on Latuda 10 daily. Has stable mood and behaviors, denies suicidal/homicidal ideation. Needs to see psych to optimize meds . Record Review of Resident #43's Physician's order report dated 05/04/25 to 06/04/25 reflected the resident was taking Latuda 10 mg once a day (antipsychotic), Trazadone 150 mg at bedtime (antidepressant), Prozac 60 mg daily (antidepressant), and buspirone 15 mg twice a day (used to treat anxiety). Record review of Resident #43's care plan with a problem start date of 04/03/25 reflected, .Behavioral Symptoms-Resident at risk for heightened emotions related to traumatic experiences related to witnessing a man shoot several people .Interventions .allow resident time to discuss emotions/trauma in a calm and safe environment as needed .consult mental health as needed .no triggers identified . Additional problems with a start date of 05/21/24 reflected, Resident has diagnosis of Post traumatic Stress disorder, at risk for anxiety, hallucinations, irritability, difficulty sleeping, lack of interest in activities, easily startled,/triggered, and loss of memory .approach .monitor/document behaviors per facility policy .administer medications per MD orders . Record Review of Resident #43's Behavioral health note dated 01/29/25 reflected an increase in buspirone to 15 mg twice a day for anxiety, continue Prozac 60 mg daily and Trazadone 150 mg at bedtime. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676120	A. Building B. Wing	06/05/2025

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #43's Behavior Monitoring log from 04/01/25 through 06/04/25 reflected the facility was monitoring for hallucinations, anxiety/fearfulness, sleepiness, and mood swings. No behaviors were reported for the monitoring period. In an interview with Resident #43 on 06/04/25 at 01:30 p.m. the resident stated he had been the witness to a shooting when he was [AGE] years old. He stated he and his wife were both present and thought they were also going to be shot. He stated it had messed with him for years. He stated the man was sent to prison. He stated the only thing that really triggered him was firecrackers or someone knocking loudly on the door. He stated he had been going to psychiatric services outside of the facility but stated he had not been in a while and was not sure why. He stated the visits did help him and he wanted to continue to receive those services. In an interview with the behavioral health Clinic Representative on 06/04/25 at 02:40 p.m. revealed Resident #43 was last seen at the clinic on 01/29/25 and was scheduled for every 2 months. The Representative stated he never returned to the clinic and there were no notes indicating why he had not returned. In an interview with the DON on 06/05/25 at 09:45 a.m. she stated she knew Resident #43 was going to an outside behavioral health service instead of their contracted psychiatric services. She stated she was not sure why Resident #43 had not been to see them since January 2025. She stated she would reach out to his MD and see if something had changed. In an interview with Resident #43's MD on 06/05/25 at 11:01 a.m. she stated she was not aware Resident #43 was not receiving his psychiatric services until today. She stated due to his numerous psychiatric issues and his medications he needed to be seen on a routine basis so that they could manage his medications effectively. She stated she gave the facility a referral today to set him up with the in-house psychiatric services. In an interview with the Social Worker on 06/05/25 at 11:30 a.m. she stated she had made a referral to the facility's psychiatric services today for Resident #43. She stated she started at the facility mid-April 2025 and was not familiar with Resident #43's outside psychiatric services. She stated she made the referrals for any of the psychiatric services requested by nursing staff, or if she identifies a need she would ask for a referral. She stated the in-house psychiatric services followed up with her while they were in house. She stated she would follow up to make sure Resident #43 was seen. In an interview with the ADON on 06/05/25 at 02:10 p.m. she stated she was the floor nurse who took care of Resident #43 in January 2025. She stated she could not remember why Resident #43's MD wanted him seen by an outside psychiatric service. She stated they would send a card with him after each of his appointments to let them know when his next appointment was, and the nurse would be responsible for placing it in the scheduling book. She stated she was not sure how the follow up appointment was missed. In a follow up interview with the DON 06/05/25 at 02:45 p.m. she stated the Social Worker would be responsible for making the referral to the psychiatric provider and following up to ensure the services had been provided. She stated failing to ensure residents received their psychiatric services could cause a delay in the resident receiving necessary services and a possible mental decline. She stated it also helped determine if the resident was on the proper medications. (continued on next page)

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	676120	A. Building B. Wing	06/05/2025

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

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled, Behavior Management- Plan of Care, dated December 2018, reflected, It is the policy of this home to document behavioral symptoms, interventions, and goals. The Plan of Care is completed and updated, in the clinical software, for a resident assess as requiring behavior intervention. It is updated per the resident's clinical status .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring and administering of all medications to meet the needs of each resident for one of five residents (Resident #70) reviewed for pharmacy services. The facility failed to ensure LVN A followed the manufacturer's instructions to prime (means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly) the Humalog pen (Insulin Lispro) (Hormone) prior to dialing in required amount of Insulin to be administered to Resident #70. These failures placed residents at risk of not receiving full dosage of medication. Findings included: Record review of Resident #70's, Face sheet, dated 06/05/25 reflected a [AGE] year-old female with a readmission date of 05/08/25. Resident #70 had a diagnosis which included Type 2 diabetes (condition where the body cannot control blood sugar and use it for energy) Record review of Resident #70's Physician's Order report dated 05/05/25 to 06/05/2025, reflected, Humalog Kwikpen Insulin (Insulin lispro) insulin pen: 100 unit/ml; amt: Per Sliding Scale; If blood sugar is . 321to 350, give 7 units . with a start date of 02/25/25. An observation on 06/04/25 at 11:35 a.m. revealed LVN A performed hand hygiene and put on gloves and entered Resident #70's room to obtain a fingerstick blood sugar. The blood sugar reading was 340. LVN A checked the computer to determine the amount of insulin per sliding scale was 7 units of Lispro insulin. LVN A retrieved the insulin pen from the medication cart. LVN A dialed in 8 units and then pushed one unit out to obtain the 7 units. LVN A then entered the resident's room and administered the insulin. In an interview with LVN A on 06/04/25 at 11:45 a.m. he stated he was not aware the pen was supposed to be primed with 2 units before each dose. He stated he had always drawn up an extra unit of what was needed and pushed out 1 unit to make sure the insulin was to the end of the needle. He stated he was not aware he was supposed to prime with 2 units and push and hold the button to clear the chamber and then dial in the amount of insulin. In an interview with the DON on 06/05/25 at 09:45 a.m. she stated the insulin pen was to be primed before each injection. She stated failure to do so could result in the resident not receiving the prescribed amount of insulin. She stated dialing in extra insulin and trying to waste 1 unit was risky and not the proper way to prime the pen. She stated they could waste 2 much or not waste enough and give the wrong amount of insulin. She stated she would in-service the nursing staff to ensure they were all aware of the proper procedure. Record review of the facility's policy, Medication Administration, dated December 2018, revealed it did not list the procedure for use of Insulin pens. (continued on next page)

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	676120	A. Building B. Wing	06/05/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a follow up interview with the DON on 06/05/25 at 12:05 p.m. she stated they followed the manufacture recommendation on the use of Insulin pens. Review of the manufacture instructions for Lispro obtained from https://www.lillyinsulinlispro.com/ searched on 06/06/25 reflected, .Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime your Pen, turn the Dose Knob to select 2 units. Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and 0 is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. If you do not see insulin, repeat priming steps 6 to 8, no more than 4 times. If you still do not see insulin, change the Needle, and repeat priming steps .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not 5% or greater. The facility had a medication error rate of 7.89 %, based on 3 errors of 38 opportunities, which involved two of five residents (Residents #19 and #26) and two of five staff (MA C and MA D) reviewed for medication errors, in that: 1. MA C administered Vitamin B-12 1000 mcg instead of Vitamin B-12 100 mcg and failed to administer duloxetine 60 mg to Resident #19's on 06/04/25 as ordered by the physician. 2. MA D failed to administer Resident #26's folic acid 1 mg on 06/04/25 as ordered by the physician. These failures could place residents at risk for not receiving therapeutic effects of their medications and possible adverse reactions. The findings include: 1. A record review of Resident #19's Quarterly MDS assessment, dated 04/04/25, reflected a [AGE] year-old female with an admission date of 07/19/22. She had a BIMS score of 15, which indicated she was cognitively intact. Diagnosis included coronary artery disease (damage or disease in the heart's major blood vessels), heart failure, depression, and muscle weakness. A record review of Resident #19's Physician's order report dated 05/05/25 to 06/05/25 reflected Resident #19 was to receive the following medications: Cyanocobalamin (vitamin b-12) tablet (mineral); 100 mcg once a day at 08:00 a.m. Duloxetine capsule 60 mg (antidepressant) twice a day at 09:00 a.m. and 09:00 p.m. During a medication pass observation on 06/04/25 at 07:25 a.m. revealed MA C administered the following medications to Resident #19: Vitamin B-12 1000 mcg 1 tablet Acidophilus 1 capsule Allergy eye drops (Naphozoline-[NAME]) 0.025-0.3 % 1 drop each eye. Glipizide 5 mg 1 tablet Metoprolol 50 mg tablet Gabapentin 100 mg 1 capsule Buspirone 10 mg 1 tablet (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Docusate 100 mg 1 tablet Flonase allergy relief spay 50 mcg 1 spray each nostril. Lidocaine patch 4% to left shoulder. Lidocaine patch 4% to lower back Miralax powder 17 grams mixed with 8 ounces of water. Ranolazine 500 mg 1 tablet Singular 10 mg 1 tablet Tramadol 50 mg 1 tablet Venlafaxine 75 mg 1 tablet Mucinex 600 mg 1 tablet Pantoprazole 40 mg 1 tablet Lasix 40 mg 1 tablet Hydrocodone-acetaminophen 7.5-325 mg 1 tablet Loratadine 10 mg 1 tablet Potassium Chloride 20 meq 1 tablet She did not administer Duloxetine 60 mg 1 capsule. Record Review of Resident #19's medication administration record on 06/04/25 at 03:00 p.m. reflected cyanocobalamin (vitamin-b12) tablet; 100 mcg at 08:00 (8 a.m.) and duloxetine capsule 60 mg 09:00 a.m. The medication was signed out as given by MA C on 06/04/25. A late administration note at 11:23 a.m. reflected: Charted late: Comment: administered on time. In an interview and observation with MA C on 06/05/25 at 04:45 a.m. MA C searched the med cart to reveal there was no B-12 100 mcg on her cart. She stated she misread the dosage and gave the 1000 mcg instead. MA C pulled all of Resident #19's morning medications and verified Duloxetine should had been given with the morning med pass. She stated she was not sure how she missed it. Stated she just got nervous. 2. A record review of Resident #26's Quarterly MDS assessment, dated 04/07/25, reflected a [AGE] year-old female with an admission date of 03/03/21. She had a BIMS score of 15, which indicated she was cognitively intact. Diagnosis included heart failure and anemia (condition in which the blood doesn't' have enough health red blood cells to carry oxygen all through the body). (continued on next page)

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	676120	A. Building B. Wing	06/05/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #26's Physician's order report dated 05/05/25 to 06/05/25, reflected Resident #26 was to receive the following medications: Folic acid tablet 1 mg once a day at 07:00 a.m. During a medication pass observation on 06/04/25 at 08:05 a.m. revealed MA D administered the following medications to Resident #26: Eliquis 2.5 mg 1 tablet Multiple-Vitamin-Minerals 1 tablet Levothyroxine 100 mcg 1 tablet Fenofibrate 48 mg 1 tablet Metoprolol 25 mg ½ tablet Omeprazole 20 mg 1 capsule Allegra Allergy 180 mg (resident refused) Potassium chloride 10 meq 1 capsule Colace 100 mg 1 capsule (resident refused) Vitamin E 180 mg 1 capsule Allopurinol 300 mg 1 tablet Vitamin B-12 500 mg 2 tablets Vitamin D-c 50,000 units 1 capsule She did not administer Folic acid 1 mg 1 tablet. Record Review of Resident #26's medication administration record on 06/04/25 at 03:10 p.m. reflected Folic Acid 1 mg 1 tablet once a day at 07:00 a.m. The medication was signed out as given by MA D on 06/04/25. In an interview with MA D on 06/05/24 08:47 a.m. verified what medications were administered to Resident # 26 on 06/04/25 and stated she missed the folic acid. She stated she was not sure how she missed it. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on 06/05/25 at 09:45 a.m., she stated she expected the staff to follow the 5 rights of medication administration which are right drug, right dose, right route, right patient, and right time. She stated failing to follow these rights put residents at risk of not receiving all their medications or could lead to drug interactions if the correct medication or dosage was not given. She stated the MAs should always go to the Charge nurse, the ADON or herself if there were any question about a medication and they should clarify with the physician if they did not have a prescribed over the counter medication in stock. Record review of the facility policy titled Medications-Administration, dated December 2018, reflected, . medications will be administered and documented as ordered by the physician and in accordance with state regulations .The residents MAR is initialed by the person administering a medication .Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the mediation label. If the label and are different and container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule .

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	676120	A. Building B. Wing	06/05/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure all drugs were only accessible by authorized personnel, for 1 of 6 residents (Resident #71) reviewed for medication storage. The facility failed to ensure Resident #71 did not have a medication named BioFreeze (a topical analgesic) at Resident #71's bedside table on 06/03/25. This failure could place residents at risk of having access to medications, resulting in harm, misuse of medication, drug diversions, and adverse reactions to medications due to improper storage. Findings included: Record review of Resident #71's Quarterly MDS, dated [DATE], reflected she was an [AGE] year-old female, admitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure), dementia (loss of cognition), and cervical disc myelopathy disorder (compressed spinal cord in the neck), with a BIMS score of 14 (intact cognition). Record review of Resident #71's care plan revealed no indication regarding her ability to self-administer her medications. Observation and interview on 06/03/25 at 11:49 AM of Resident #71's room with CNA Q revealed a tube of BioFreeze on Resident #71's nightstand. She stated that Resident #71 had not asked for her to apply it and she had seen it in her room and thought nursing was aware. In an interview on 06/03/25 at 12:18 PM with the ADON she stated that she became aware that the resident had BioFreeze at her bedside recently and had told a CNA to remove it and did not know it was still at her bedside. She stated that the risk to a resident to have BioFreeze at the bedside would be nursing would not know if the resident had applied it or it could be used by another resident. She stated over the counter medications are supposed to be stored in the medication carts and residents needed to have a physician order for the medication. In an interview on 06/04/25 at 1:34 PM with CNA P she stated that the BioFreeze had been at Resident #71's bedside since she admitted to the facility and thought it was for the resident's legs. She stated Resident #71 never asked her to apply it on her. In an interview on 06/04/25 at 2:06 PM with Resident #71 revealed the BioFreeze came with her from another facility, it's used to help her legs, and was not sure when the last time it was applied to her legs. She stated she thought LVN R might have applied it to her legs once but was not sure. Observation of Resident #71's hands revealed she had difficulty using her hands due to contractures. (continued on next page)

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	676120	A. Building B. Wing	06/05/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/04/25 at 7:04 PM with LVN R revealed she was not aware that Resident #71 had BioFreeze at her bedside and stated that it was not one of the resident's prescribed medications and Resident #71 was not able to apply it herself due to her hand contractures . She stated it was important to ensure medications were stored, even over the counter medications, because they needed to know how often the medication was administered, ensure it was administered properly, and to prevent accidents like another resident getting a hold of the medication or Resident #71 rubbing their eyes after using the medication after using the BioFreeze. In an interview on 06/05/25 at 10:55 AM with the DON she stated all medications, even over the counter medications, needed a physician order and should be locked in a nurse's cart because it insured resident safety and prevented accidents. She stated over the when staff round on residents they can see if an over the counter was in open view. She stated that she expected CNA's to inform nursing if they saw an over the counter medication at a resident's bedside and nursing would remove it and educate the resident on why they cannot have over the counters at the bedside and verify if there was an physician order if the resident needed or requested the medication. She stated that staff are trained on the process for medication administration that includes ensuring medications, even over the counters, are stored in a secure location. She stated it was possible Resident #71's family brought it to Resident #71 . Record review of the facility's medication policy, titled Medication- Administration, dated December 2018, reflected: It is the policy of this home that medications will be administered and documented as ordered by the physician and in accordance with state regulations . PROCEDURE 1. Medications are prepared, administered, and recorded only by licensed nursing, certified medication aides, medical, pharmacy, or other personnel authorized by state laws and regulations. to administer medications. 2. Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with guidelines for self -administration of medications .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide food and drink that was palatable for one meal (Lunch 6/3/25) observed for 3 out of 18 residents (Resident #227, Resident #56 and Resident #177) for food palatability and food form. The facility failed to provide palatable lunch meal on 6/3/25 for 3 residents. This failure could place residents at risk of decline in nutrition status, loss of appetite, and decreased intake placing them at risk for unplanned weight loss. Findings included: 1. Review of Resident #227 admission Minimum Data Set (MDS) Assessment, dated 5/13/25, reflected she was a [AGE] year-old female with an admission date of 5/6/25. Resident #227 had no impairment to her cognition and had a BIMS score of 15. Resident was to have a therapeutic diet while a resident at the facility. She had the following diagnoses: Diabetes (a group of diseases that result in too much sugar in the blood), Malnutrition, Anemia (a condition marked by a deficiency of red blood cells or hemoglobin in the blood), Gastroesophageal Reflux Disease (a condition in which stomach contents flow back up into the esophagus, causing irritation and discomfort), and muscle weakness. Review of active physician order dated 5/8/25 for Resident #227 reflected Diet - NSOT diet, Diabetic, Regular texture, Thin Liquids, 1500ml fluid restriction. Lactose intolerant. Review of Resident #227's Care Plan dated 5/8/25 reflected .Problem Start Date: 06/03/2025 Category: Dietary Resident is at nutritional/weight variance risk r/t therapeutic diet, lymphedema, diuretic therapy, kidney disease and diabetes .Approach Start Date: 06/03/2025 Diet as ordered Created: 06/03/2025 . Interview with Resident #227 on 6/3/25 at 10:13am revealed the food at the facility was not great, it was cold and bland most of the time. Resident stated she had told multiple staff of her concerns with the food. In an interview with Resident #227 on 6/4/25 at 9:00am revealed she had not eaten the fried chicken lunch the day before, as her friend had brought her lunch. She frequently had her friend bring her food because the food was so awful. 2. Record review of Resident #56's Comprehensive MDS, dated [DATE], reflected she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of heart failure and diabetes (high blood sugar) with a BIMS score of 15 (intact cognition). (continued on next page)

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	676120	A. Building B. Wing	06/05/2025

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #56's care plan reflected she had congested heart failure and interventions included to monitor and document food preferences, dated 05/06/25. In an interview and observation on 06/03/25 at 1:37 PM with Resident #56 revealed she was seated in her room with her a plate of fried chicken with strips of meat pulled apart on her plate and mashed potatoes with gravy and stated that the food was not good. She stated she was able to get an alternative meal if she were to ask and she had not spoken with a CNA yet. She stated she was not able to eat the fried chicken because it was too tough. 3. Record review of Resident #177's Comprehensive MDS, dated [DATE], reflected she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of anemia (low iron), kidney disease, heart failure, and diabetes (high blood sugar) with a BIMS score of 15 (intact cognition). Record review of Resident #177's care plan reflected she was at risk for pressure ulcers due to diabetes and incontinence, interventions included monitor nutritional status, serve diet as ordered and monitor intake, dated 01/08/25. Record review of Resident #177's physician order's reflected an order with a start date of 06/02/25 for a Renal diet, Regular texture, thin liquids. In an interview and observation on 06/03/25 at 1:43 PM with Resident #177 she was seated in front of her bedside table with a plate of fried chicken with mashed potatoes and gravy and stated that the food was not good. Resident #177 stated the fried chicken was too tough and dry and the mashed potatoes were not edible. She stated she had not yet told a staff member that she did not like the meal. In an interview on 06/04/25 at 1:34 PM with CNA P she stated that she had heard residents complain about food at the facility- either it was too cold, or not what they ordered, or it had not flavor. She stated that they always have available a alternative meal for residents who wanted something other than what was served. Record review of Week At a Glance menu for 6/3/25 Lunch reflected .Meal of the Month, fried chicken, mashed potatoes, broccoli w/ cheese sauce, dinner roll, chocolate pie . Record review of Resident Council Minutes on 3/10/25 reflected .Dietary: Hall trays are cold . Record review of Resident Council Response Sheet dated 3/10/25 reflected .we have ordered more dome lids and bases to help keep the food hot. If you food is cold, please let someone know so they can get you hot food. We don't want anyone to eat cold food . Record review of Resident Council Minutes on 5/12/25 reflected .Dietary: .Lunch and dinner late sometimes . Record review of Resident Council Response Sheet dated 5/12/25 reflected .I will work with the nursing department on getting staff in the dining room on time so meal service can start on time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676120	A. Building B. Wing	06/05/2025

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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Facility mealtimes reflected Main Dining Room Breakfast 7:00 - 8:30, Lunch 11:30 - 1:00, Dinner 5:00 - 6:30. Hall Delivery Schedule Breakfast 100, 200, 300 Lunch 200, 300, 100, Dinner 300, 100, 200. Hall trays are delivered after the dining room is served. The hall trays follow the above schedule once the dining room service is complete. Residents residing on the above halls can expect their trays within the listed mealtime. Record review of Dining Manager Fried Chicken Recipe reflected .Preheat oven to 425 F - Convection oven 1. place the chicken and milk in a container with lid .pour melted margarine on sheet pan. 4. Remove chicken from milk and dredge each piece in flour .6. Bake 12 minutes. Carefully remove pan from oven and turn the chicken pieces over bake another 12 minutes until chicken reaches desired temperature . maintain 165F or above . Observation of fried chicken being cooked on 6/3/25 at 11:26am revealed chicken piece soaking in a bowl of milk, dipped in a flour mixture and tossed in the fryer. Chicken was observed to be tempted after removal from fryer. Fried Chicken was tempted at the holding table at 170 degrees. Observation and interview of residents in the Main Dining room on 06/03/25 at 11:59am revealed 4 residents stated the food was horrible. They hate the food in general. They complained the chicken served today was overcooked and hard to chew. Residents stated the meal being service was the residents' choice for meal of the month. Observation of lunch tray delivery in the 100 hall on 6/3/25 revealed the last resident received her tray at 1:05pm. The test tray was delivered to the conference room at 1:06pm and was tested by 3 surveyors. The test tray arrived with the following items: 1 piece of fried chicken, broccoli w/ cheese, mashed potatoes and gravy, chocolate pie and a dinner roll. The food on the tray was lukewarm. The fried chicken was dry with little to no taste, and it was difficult to chew. The broccoli was bland and mushy, the cheese sauce on top of the broccoli had no salt and did not taste like cheese. The mashed potatoes and gravy were good consistency with some salt. The chocolate pie was cool, sweet, and moist with whip cream. The following condiments were provided, salt, sugar, and butter. A glass of unsweetened tea and water were provided with a few pieces of ice in each cup. In a confidential group interview on 6/4/25 at 11:02am residents stated food at the facility was mostly served cold and on occasion warm. When food was late it tasted terrible. They stated the trays of food sit in the halls for long periods of time for those who were eating in their room. Residents in the dining hall were usually finished eating by the time residents in the hallways got their food. The resident in their rooms may eat an hour after the residents in the dining room. Residents complained about overcooked vegetables and undercooked beans. They stated temperature of food had not gotten any better even after the changes the facility had made. Residents also stated the food had no flavor and had to add their own seasoning. (continued on next page)

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	676120	A. Building B. Wing	06/05/2025

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator on 6/5/25 at 10:00am revealed the facility does not have a policy on food palatability. He stated they go by common standards. He stated they had bought warming trays for the trays in the hallway to help ensure the food was warm and had purchased a warming tray. He was informed the test tray food was lukewarm, the chicken was hard to chew, and the food was bland. He stated the taste of food was dependent on personal choice and they cannot accommodate everyone's taste. He stated they have been providing alternate foods from available all the time meals to residents who did not want the regular menu food. He stated all menus were based on recipes provided by Nutritious Lifestyle. He stated it was a resident choice meal, as it was requested from Resident Council. He stated the risk to the residents of not having palatable food was it could affect their eating and weight. Review of the facility's policy Menu Planning revised on June 1, 2019 reflected .The facility believes that nutrition is an important part of maintaining the wellbeing and health of its residents and is committed to providing a menu that is well balanced, nutritious and [NAME] the preferences of the resident population .

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	676120	A. Building B. Wing	06/05/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews 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: 1. The facility failed to ensure food items in the facility freezer were dated or labeled. 2. The facility failed to ensure during lunch service kitchen staff used proper hand hygiene while serving residents' trays on 6/3/25. 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 Include: Observation of freezer in the kitchen and interview with Dietary Manager on 06/03/25 beginning at 9:16 am: -clear opened to the air plastic bag with about 25 corn dogs, in an unsecured box labeled corn dogs. Dietary Manager stated the bag should be closed and proceeded to close it by making a knot on top. -clear opened to the air, plastic bag with about 30 1.5-inch circular disc inside an unsecured box. The Dietary Manager stated they were biscuits and took the box out and knotted the plastic bag and labeled it. -clear opened to the air, plastic bag in a broken box with about 20 dinner rolls. The Dietary Manger took the bag out of the box and removed the box. She then sealed the bag, labelled it, and put the bag back into the freezer. She stated the bag should have been properly sealed. Interview with Dietary Manager on 6/3/25 at 9:25am revealed the expectation was all food should be dated in the refrigerator and freezer when received and when opened it should be dated with date opened. Every item should be labeled of what it was if not in original box or bag. Once something was opened it needed to be sealed with a knot or tied in original packaging if possible. The risk to the residents was freezer burn and cross contamination if the food was consumed. She stated she would be providing a refresher training and in-service to kitchen staff to remind them of her expectations. (continued on next page)

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	676120	A. Building B. Wing	06/05/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Dietary Aide N on 6/3/25 at 11:46am revealed he was carrying a tray of water and tea during lunch service and the trays were being held with two hands, but several cups were touching his shirt. He put the trays down on the metal serving table and wiped shirt and pants with bare hands, left the area toward the dishwashing area and grabbed gloves, returned, and put gloves on, he then proceeded to put plastic tops on each glass of water and tea. He did not wash his hands before putting the gloves on. Dietary Aide N then took the dirty gloves off and threw them on the serving table, where food was being held and left to the back of the kitchen. He returned with new gloves and put them on. He then touched his pants, dug in his pockets with the gloves on and proceeded to put drinks on the food trays. He also put his gloved hands on his pants while looking at the hall trays on the bottom shelf of the cart and proceeded to grab cups of tea and water and put them on those trays. Interview with the Dietary Manager on 6/3/25 at 12:50pm revealed hand hygiene requires kitchen staff to wash their hands between task, when they wear gloves, they were supposed to wash hands before putting gloves on. When cooks or aides go to the back to get something they should wash hands and put new gloves on. Kitchen staff should not touch clothing or other surfaces that could contaminate food. The risk to the residents was cross contamination and issues with infection control. Interview with Dietary Aide N on 6/3/25 at 1:23pm revealed he should have washed his hands when he passed the threshold of the serving area. He stated he did not know he could not put the serving trays on his clothing while carrying them but realized he could cross contaminate food and bacteria on his clothing could get on the food served to the residents. He stated he was supposed to throw away dirty gloves in the trash and should not touch clothes when he had gloves on. He stated he should wash his hands with soap and water in between glove changes and when touching his clothes or personal items. Review of the Facility's policy Hand Washing effective 12/2018 reflected .1. They use of gloves does not replace proper hand washing .Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions .before and after eating or handling food (handwashing with soap and water) .after removing gloves or aprons . Review of the Facility's policy Food Storage date approved 4/26/19 reflected .Freezers .e. store frozen foods in moisture-proof [NAME] or containers that are labeled and dated . 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676120	A. Building B. Wing	06/05/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for four (Resident #70, Resident #66, Resident #19, and Resident #61) of seven residents observed for infection control. 1. The facility failed to ensure LVN A used the required PPE for Resident #70, who was on enhanced barrier precautions due to her venous access device, while administering resident IV antibiotics on 06/04/25. 2. The facility failed to ensure LVN A and LVN B decontaminate the glucometers which were used to obtain a fingerstick blood sugar on Resident's #70 and Resident # 66 when they failed to allow the glucometer that was sanitized with a germicidal wipe to air dry before returning the glucometer to the medication cart and laying it on top other supplies inside the medication cart. 3. The Facility failed to ensure MA C did not cross contaminate Resident #19's eye drops and nose spray when she carried the items into the resident's room on 06/04/25 and did not perform hand hygiene before administering resident eye drops. 4.The facility failed to ensure CNA E performed hand hygiene before and after transferring Resident #61 to her wheelchair and before leaving the residents' room. Theses failure placed residents at risk for infection and cross contamination. Findings included: 1. Record review of Resident #70's admission MDS assessment dated [DATE] reflected a [AGE] year-old female admitted to the facility on [DATE]. Resident had a BIMS score of 13 which indicated she was cognitively intact. Diagnoses included type 2 diabetes mellitus and Osteomyelitis (infection in the bone). Record review of Resident #70's comprehensive care plan initiated on 02/24/25, reflected, Resident requires Enhanced Barrier Precautions (infection control strategy used to reduce the transmission of Multiple drug resistant organisms) during contact care related to central lines .Interventions .Staff to provide/utilize appropriate PPE along with standard precautions while providing resident care. (i.e. wound care, care to .IV sites .) An observation of the medication pass on 06/04/25 at 08:30 a.m. revealed LVN A at the medication cart preparing Resident #70's intravenous antibiotic. LVN A performed hand hygiene and put on gloves, but no gown. Signage was observed on the door indicating Resident #70 was in EBP. LVN A entered Resident #70's room and cleaned the PICC line (a long, flexible tube that is inserted into a vein in the arm and used to deliver medications) lumen (access device) with an alcohol wipe and flushed the PICC line with 10 cc of Normal Saline. LVN A then connected the IV line to the PICC line for the medication administration. LVN F returned to the medication cart and removed his gloves and performed hand hygiene. (continued on next page)

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	676120	A. Building B. Wing	06/05/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A second observation on 06/04/25 at 09:50 a.m. revealed LVN A perform hand hygiene and put on glove, but no gown. He entered Resident #70's room to disconnect the IV infusion. LVN A disconnected the IV line from the resident's PICC line and flushed the PICC line with 10 cc of normal saline. LVN A removed his gloves and performed hand hygiene. In an interview with LVN A on 06/04/25 at 09:55 a.m. he stated Resident #70 was on Enhanced Barrier Precautions because of her surgical wound on her back. He stated the resident was on EBP because of her wound. When asked what other times enhanced barrier precautions were required, he stated anyone with an access device and then stated he should have worn a gown when providing her IV medications. He stated he had been in serviced on the use of Enhanced Barrier Precautions and what PPE was required but still gets confused at times of what is required for what. In an interview with the DON on 06/04/25 at 10:05 a.m. she stated any resident with an indwelling device, such as a PICC line, required the use of Enhanced Barrier precautions. She stated signs are posted on the door to make sure staff is aware of what type of precautions are required. She stated she will re-Inservice staff again. She stated the purpose of the enhanced barrier precautions is to prevent the potential spread of MDRO's to other residents in the facility. 2. Record review of Resident #70's admission MDS assessment dated [DATE] reflected a [AGE] year-old female admitted to the facility on [DATE]. Resident had a BIMS score of 13 which indicated she was cognitively intact. Diagnoses included type 2 diabetes mellitus and Osteomyelitis (infection in the bone). A record review of Resident #66's undated face sheet reflected a [AGE] year-old female with an admission date of 06/30/24. Diagnosis included diabetes. An observation on 06/04/25 at 11:35 a.m. revealed LVN A at the medication cart preparing to perform Resident #70's fingers stick blood sugar (FSBS). LVN A put on gloves, removed the glucometer from the medication cart, wiped the glucometer down with a germicidal wipe and placed it on a tissue on top of the medication cart. LVN A removed his gloves, performed hand hygiene, and put on clean gloves. LVN A entered the resident's room to perform the FSBS, pricked Resident #70's finger and obtained a blood sample for FSBS. LVN A returned to the medication cart, removed the test strip, and disposed of it and the lancet. LVN A removed his gloves and performed hand hygiene. LVN A re-gloved and retrieved a germicidal wipe (with a kill time of 1 minute) and wiped the glucometer with the germicidal wipe and immediately placed the glucometer back into the cart on top of other supplies in the medication cart, without letting the glucometer air dry. In an interview with LVN A on 06/04/25 at 11:45 a.m. he stated he was not sure how long the contact time was for the germicidal wipe he used to clean the glucometer. LVN A reviewed the contact time on the EPA approved germicidal wipe and determined it was for 1 minute. He stated by not letting the glucometer air dry there was the potential for cross contamination and could potentially expose residents to blood borne pathogens. He stated he should have let it dry before placing it back in the cart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676120	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 06/04/25 at 12:05 p.m. revealed LVN B at the medication cart preparing to perform Resident #66's fingers stick blood sugar (FSBS). LVN B put on gloves, removed the glucometer from the medication cart, wiped the glucometer down with a germicidal wipe and placed it on a tissue on top of the medication cart. LVN B removed her gloves, performed hand hygiene, and put on clean gloves. LVN A entered the resident's room to perform the FSBS, pricked Resident #66's finger and obtained a blood sample for FSBS. LVN B returned to the medication cart, removed the test strip, and disposed of it and the lancet. LVN B removed her gloves and performed hand hygiene. LVN B re-gloved and retrieved a germicidal wipe (with a kill time of 1 minute) and wiped the glucometer with the germicidal wipe and immediately placed the glucometer back into the cart on top of other supplies in the medication cart, without letting the glucometer air dry. In an interview with LVN B on 06/04/25 at 12:05 p.m. she stated she was not aware she had to allow the surface of the glucometer to dry before placing it back in the cart. She stated she knew she had to disinfect between each resident to prevent the spread of blood borne pathogen. She stated no one had reviewed with her about contact time for proper disinfecting. In an interview with the DON on 06/05/25 at 12:00 p.m. she stated staff needed to make sure all equipment was cleaned with appropriate germicidal wipes between patient use especially glucometers. She stated the glucometers had to remain visibly wet for the appropriate contact time for the glucometer to be considered sanitized. She stated they should always let them air dry and should not place them back into the cart until they are dry. She stated this failure placed residents at risk of the spread of germs and cross contamination. She stated the facility does not have a policy specific to glucometer disinfection so they would follow the manufactures recommendation. She stated she would be in servicing the staff on proper protocol for sanitizing the glucometer. 3. A record review of Resident #19's Quarterly MDS assessment, dated 04/04/25, reflected a [AGE] year-old female with an admission date of 07/19/22. She had a BIMS score of 15, which indicated she was cognitively intact. Diagnosis included coronary artery disease (damage or disease in the heart's major blood vessels), heart failure, depression, and muscle weakness. During a medication pass observation on 06/04/25 at 07:10 a.m. MA C was observed at the medication cart. MA C sanitized her hands and pulled Resident #19's oral medications. MA C then retrieved a box containing the resident's allergy eye drops and a box containing the resident's Flonase (allergy spray). MA C entered the resident's room and placed the box of eye drops and nose spray on top of the resident bedcovers. MA C then removed the blood pressure cuff from the resident's arm and administered her oral medications. MA C then opened the eye drops box and removed the bottle of eye drops. MA C put on gloves without performing hand hygiene and applied one drop in each eye and then removed the nose spray from the box and sprayed one spray to each of the resident's nostrils. MA C then placed the nose spray and eye drops back into their box and placed them on the resident's wheelchair. MA C called for assistance to reposition the resident in the bed. MA C and another staff member lifted the resident up in the bed. MA C then removed her gloves, gathered up the box of eye drops and nose spray and went to leave the room. The bottle of eye drops fell out of the box and hit the floor. MA C picked up the bottle of eye drops and returned it to the medication cart. When reaching to place the eye drop bottle, the box for the eye drops and the box of nose spray onto the cart, MA dropped the box for eye drops onto the floor. MA C picked up the box and then placed the bottle of eye drops back in the box that had just been on the floor. MA C then placed both the box of eye drops and the box of nose spray back into the top of the medication cart. (continued on next page)

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	676120	A. Building B. Wing	06/05/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with MA C on 06/04/25 at 08:00 a.m. she stated she should not have taken in the boxes for the eye drops and Flonase and should not have placed them on the bed or resident's chair due to cross contamination risk. She stated she should have performed hand hygiene before putting on her gloves to do the eye drops. She stated she should have disposed of the eye drops when she dropped them on the floor. In an interview with the DON on 06/05/25 at 09:45 a.m. she stated the MAs were trained not to carry in the boxes for any medication into the resident's room and if they had to set a bottle of drops or nose spray down, they had to place it on a barrier. She stated it should never by placed on the resident's bedcovers or chairs. She stated any medication dropped on the floor was to be discarded. She stated hand hygiene was to be performed every time before putting on gloves and especially before administering eye drops. She stated they would in-service MA C on infection control. 4. Record review of Resident #61's undated face sheet reflected a [AGE] year-old female admitted to the facility on [DATE]. Diagnosis included reduced mobility and hemiplegia (partial paralysis on one side of the body) following unspecified cerebrovascular (blood vessels that supply the brain) disease. An observation on 06/03/25 at 10:30 a.m. revealed CNAs E and F entered Resident # 61's room to perform a mechanical lift transfer. Both staff performed hand hygiene. CNA F put on gloves, but CNA E did not. Both staff attached the mechanical sling to the lift and then transferred the resident to her wheelchair. CNA F removed her gloves and performed hand hygiene. CNA E straightened up the resident's bed linens and then pushed the resident down the hall to the dining room area without performing hand hygiene. In an interview on 06/03/25 at 10:38 a.m. with CNA E, she stated she only had to wear gloves to do incontinence care. She stated since Resident #61 was dressed and there was no contact with body fluids, she did not have to wear gloves. She stated she was supposed to do hand hygiene before she started anything but was not aware she had to do hand hygiene after just contacting a resident or items in their rooms. She stated she had worked for 10 years and was not aware that was a requirement. In an interview with the DON on 06/05/25 at 12:05 p.m. she stated staff were to perform hand hygiene when they entered a resident's room, after contact with any resident, or items in the resident's room and before leaving the resident's room. She stated by not following standard precautions with hand hygiene it placed residents at risk of infections and cross contamination. She stated she had only been in this role since the end of March and was conducting in-services as areas of concern came up. She stated they would be doing another Inservice on infection control. Record review of the facility's policy, Infection control-Precautions-Categories and Notices, revised on March 2024, reflected, .In addition to Standard Precautions, Contact precautions must be implemented for resident known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident .Gloves and hand washing .remove gloves before leaving the room .Gown- In addition wearing a gown .when entering the room if you anticipate that your clothing will have substantial contact with the infectious material .For residents for whom EBP are indicated, EBP is employe when performing the following high-contact care activities .Device care or use: central line .Wound care: any skin opening requiring a dressing (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676120	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy, Infection Control-Cleaning and Disinfecting Resident Care items and equipment, dated December 2018, It is the policy of this home to clean and disinfect resident-care equipment, including reusable items and durable medical equipment per current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard .Reusable resident care equipment will be decontaminated and/or sterilized between residents per manufactures' instructions . Record review of the manufacturers guidelines searched on 06/10/25 at https://www.medline.com/media/catalog/Docs/MKT/LIT302_MAN_EvenCare, reflected, .To clean the meter, clean with one of the validated disinfecting wipes .Wipe all external areas of the meter including both front and back surfaces until visibly clean. Avoid wetting the meter test strip port. Allow the surface the meter to remain wet at room temperature for the contact time listed on the wipe's directions for use. Wipe meter dry or allow to air dry Review of the facility's policy titled, Hand Washing, dated December 2017, reflected, .Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions .Before and after contact direct resident contact; Upon and after coming in contact with a resident's intact skin (e.g., when taking a pulse or blood pressure, and lifting a resident) .after handling soiled equipment . After removing gloves .