STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455563	A. BUILDING _____ B. WING _____	**09/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DENISON NURSING AND REHABILITATION LP	**601 E HWY 69 DENISON, TX 75021**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to incorporate recommendations from a PASRR evaluation report into a resident assessment, care planning, and transition of care for one (Resident #33) of four residents reviewed for PASRR services. The facility failed to ensure a complete and accurate PASRR Nursing Facility Specialized Services (NFSS) request form for OT and PT was submitted into the Texas Medicaid & Healthcare Partnership (TMHP) portal within 20 business days after the date of the Interdisciplinary Team (IDT) meeting to facilitate services for Resident #33 as agreed upon in the meeting. This failure placed residents at risk of not receiving specialized PASRR services that would enhance their highest level of functioning. Findings included: Review of Resident #33's admission MDS, dated [DATE], reflected he was a [AGE] year-old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. He was evaluated by level II PASRR and was determined to have [MEDICAL CONDITION]. Resident #33 had zero minutes of physical, occupational and speech therapy. Review of Resident #33's discharge MDS, dated [DATE], reflected he was discharged from the facility on 07/10/20. Review of Resident #33's PASRR Level 1 screening, dated 02/14/20, reflected he was positive for PASRR for an intellectual and developmental disability. Review of Resident #33's PASRR Evaluation, dated 02/27/20, reflected Resident #33 had [DIAGNOSES REDACTED]. The evaluation reflected PASRR services recommended Resident #33 receive specialized occupational therapy, specialized physical therapy, durable medical equipment and specialized speech therapy, to be provided/coordinated by nursing facility. Review of Resident #33's Initial Care plan meeting with LAR, dated 03/05/20, at 11:00 AM reflected Habilitation Services of OT and PT assessment and service. Goal to gain strength to return home. Review of Resident #33's Initial IDT meeting in the TMHP portal, dated 03/05/20, reflected the PASSR recommendations of Specialized Occupational Therapy, Specialized Physical Therapy and durable medical equipment of gait trainer for Resident #33. Review of Resident #33's Nursing Facility Specialized Services request form in the TMHP portal reflected a status date of 04/02/20 and form was not accepted. The following errors were returned from TMHP: (Fatal) The Occupational Therapy (OT) request cannot be processed because the person does not have a Daily Care Service Authorization for the submitted Provider No. (Number) as the date of the assessment. Correct the OT Date of Assessment or submit the necessary paperwork to establish the Daily Care Service Authorization before resubmitting the NFSS from. The recommended Habilitation - Physical Therapy was three times a week for one month. Review of Resident #33's Occupational Plan of Care with start date of 03/17/20 and signed by OT reflected (Resident) is a PASSR resident who will benefit from skilled OT services to work on areas such as strength, balance, simple mobility, endurance and self-care skills. Review of Resident #33's Physical Therapy Plan of Care with start date of 03/17/20 signed by PT reflected (Resident) referred to PT services under PASSR services in order to maintain current level of function. Review of Resident #33's Quarterly IDT meeting, dated 05/27/20, reflected LAR is not interested in any PASRR specialized services as individual is going back to group home ASAP (as soon as possible). Review of Resident #33's Physical Therapy Progress and updated Plan of Care with start date 03/17/20 and signed on 06/10/20 reflected no treatments since last report and awaiting approval from PASSR. Interview on 09/03/20 at 11:30 AM with the Director of Rehab revealed Resident #33 did not receive any PASRR services of Occupational or Physical Therapy due to the facility not receiving approval. She stated the request was sent in via the portal for PT and OT PASSR services but there was an error. She stated she did check the request but could not recall when and was told by LTC portal the issue was with MDS not her. She stated Resident #33 did not receive any skilled OT or PT services while he was at the facility. Interview on 09/03/20 at 2:31 PM with Regional MDS Coordinator revealed therapy had only access to input or correct information in the portal with PASSR therapy services. She stated in the initial IDT for Resident #33 it was discussed for him to receive PASSR OT and PT services. Interview on 09/03/20 at 3:50 PM with the DON revealed she would expect Resident #33 to have received PASSR services as agreed upon during IDT meetings. She stated if there were problems with PASSR approval she would expect follow-up to ensure completion. Review of facility's policy Preadmission Screening and Resident Review, dated January 2020, reflected Each resident is screened for a mental disorder (MD) or intellectual disability (ID) and that individuals identified with MD or ID are evaluated and receive care and services in the most integrated setting appropriate to their needs.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observations, interviews and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for the facility's only kitchen. 1. The facility failed to ensure food in the kitchen's refrigerator and dry storage were stored in sealed containers, labeled, and dated. 2. The facility failed to maintain cleanliness of the inside of two of two ovens. These failures placed residents at risk for food contamination and food-borne illness. Findings included: 1. Observations of the kitchen's dry storage on 9/01/20 at 9:15 AM revealed the following: - a resealable bag of chocolate chips with sticky substances on outside of bag; not sealed with an open date of 4/01/20. - a resealable bag of graham cracker crumbs undated. Interview on 9/01/20 at 9:23 AM with Dietary Cook F revealed she was not sure when the graham crackers were opened but there should have been a date on the bag and the bag of chocolate chips should have been sealed. She stated when the food item is opened it should be dated and sealed. Observation on 9/01/20 at 9:17 AM of one of two refrigerators revealed a plastic container with lunch meat was not dated or labeled. Interview on 9/01/20 at 9:23 AM Dietary Cook F stated the plastic container with lunch meat was ham. She stated she was not sure when it was put in the refrigerator but it should be labeled and dated when opened so they would know how long it was good for. Interview on 9/01/20 at 9:28 AM the Dietary Manager stated food items should be dated, labeled and sealed properly. He stated food items should be dated when they were opened. Review of facility's policy Food Storage, revised November 2018, revealed, Food will be stored in a safe and sanitary method to prevent contamination and food-borne illness .4. Food removed from its original packaging will be dated and labeled .7. All opened containers or leftover food is to be tightly wrapped or covered in clean containers. It should be labeled, dated with opened or use by date. Review of the U.S. Public Health Service Food Code, dated 2017, 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking: commercially processed food, revealed, .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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) 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. 2. Observations on 9/01/20 at 9:21 AM revealed two of two ovens had a black substance covering the bottoms of ovens. Interview on 9/01/20 at 9:25 am Dietary Cook F stated she believed the ovens were cleaned monthly but she was not sure when they were last cleaned. Observation on 9/02/20 at 2:28 PM revealed two of two ovens had a black substance covering the bottoms of ovens. Interview on 9/03/20 at 8:45 AM the Dietary Manager stated the ovens were to be cleaned monthly. In an follow-up interview at 10:20 AM, after receiving facility cleaning schedule, the Dietary Manager stated the ovens should be cleaned weekly but the ovens had not been cleaned for about a couple of weeks. He stated he was responsible for overseeing the cleaning schedule. Review of facility's August 2020 weekly cleaning schedule revealed ovens (interior) were to be cleaned weekly. Weeks three through five showed the ovens were not cleaned. Review of facility's policy Cleaning Schedules, revised August 2018, revealed, Food preparation areas, food production areas, equipment will be cleaned on a regularly scheduled basis .1. It is the responsibility of the Food and Nutrition Services Director (FNSD) to prepare the daily, weekly, and monthly cleaning schedules. The FNSD, or designees, monitors sanitation on a daily basis .3. It is the responsibility of all employees to follow the cleaning schedule. Review of the U.S. Public Health Service Food Code, dated 2017, 4-602.12 Nonfood-Contact Surfaces revealed, Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues.
F 0825 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or get specialized rehabilitative services as required for a resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to obtain specialized rehabilitative services for one (Resident # 24) of two residents reviewed for specialized rehabilitative services. The facility failed to ensure Resident #24 received (ST) evaluations/treatment to determine if the resident's diet could be safely upgraded from a pureed diet with thickened liquids to a regular diet per family request. This failure placed residents with swallowing difficulties at risk of not meeting their highest practicable well-being and result in choking and aspiration pneumonia. Findings included: Review of Resident #24's MDS assessment, dated 07/30/20, revealed the resident was a [AGE] year-old female admitted from another facility on 06/11/20. The resident's [DIAGNOSES REDACTED]. Resident #24's MDS reflected she was severely cognitively impaired and required extensive assistance with eating and all ADL care. Nutritional approaches reflected she had been on a mechanically altered diet and had received no services from ST or OT in the past seven days. Review of Resident #24's Nurse's admission notes, dated 06/11/20 revealed, .Language barrier .Chewing/Swallowing problems .Unable to feed self . Review of Resident # 24's admission orders [REDACTED]. Review of Resident #24's care plan from the previous SNF, dated 06/11/20, reflected, .is at risk for choking and aspiration as evidenced by difficulty chewing .Interventions included .If resident does not want head of bed elevated, call the nurse and do not leave food within reach. ST to eval . Review of Resident #24's admission care plan, dated 06/11/20, did not address Resident #24's choking risk or goals and interventions to prevent aspiration. An interdisciplinary resident screen for therapy, dated 06/25/20, for Resident #24 was signed by the Director of Rehabilitation and indicated, Request for PT/OT services. ST was not requested. An observation on 09/02/20 at 11:45 a.m. revealed a regular texture diet was delivered to Resident #24's room. Resident #29 (spouse to Resident #24) stated, She eats what I eat, but I make sure I cut it up in very small pieces for her, Review of Physician Telephone orders, dated 09/01/2,0 revealed, Regular please feed per family. Review of Against Medical Advice for Nutrition issues form revealed, Your physician has ordered the following diet for you: puree Nectar Thick liquids. This diet/fluids order is designed to treat the following conditions, [DIAGNOSES REDACTED].Failure to follow the diet order can results in the following risks .Aspiration pneumonia .recurrent lung infections .Choking or coughing . The verbal consent was provided by the resident's family member and witnessed by RN B and the ADON on 09/01/20 over the phone. Interview with the Resident #24's POA on 09/03/20 at 9:57 a.m. revealed someone from the facility had called him the previous week, but not on 09/01/20, and told him his father was wanting a regular diet for Resident #24. He stated he told them the only way he would agree to it was that the resident had to be sitting up in a chair and someone had to be with her at all times. He stated they explained about her choking risk due to her stroke but did not explain that it could lead to pneumonia. Resident #24's POA stated he just wanted his mother to be happy. He stated she had choked three times at the previous facility and had to be sent out to the hospital at least once because she choked on a hotdog. He stated no one discussed any therapy with him and the only time the resident received any therapy was when she was in a rehab hospital. Interview with RN A on 09/03/20 at 3:12 p.m. revealed she was the nurse who contacted Resident #24's POA, about Resident #29's request for a regular texture diet for Resident #24, one day last week. She stated he did tell her he would agree to the diet texture change only if Resident #24 was sitting up and someone was with her, which she stated is why she feeds her on her shift. RN A stated she conducted the admission assessment for Resident #24 and she would have normally referred her to ST, but was told they did not have ST. She stated she knew the resident was a choking risk due to her dysphagia and her stroke. Interview with the RD on 09/03/20 at 9:01 a.m. stated under normal circumstances, any resident admitted to the facility on a pureed diet would be picked up by ST to determine if the diet was appropriate and if they could progress to a less restrictive diet. She stated since COVID the facility was not allowing ST staff to come into the building since they worked at other facilities and this facility did not have a full time ST. She stated they still did not have ST available in the facility. According to the American College of Health Care Administration, https://achca. reviewed on 09/18/20, Managing the Risks while Honoring Residents' Person-Centered Diet Choices, reflected Providers should document .A choice has been given to the resident .The resident has received adequate information The Ethical Concerns section of ASHA's Adult Dysphagia Practice Portal advises SLPs to: Educate the involved parties about possible health consequences and to document all communication with the resident and caregivers . Interview with the ADON on 09/03/20 at 9:30 a.m. revealed that nursing services could not upgrade a diet order. She stated the Resident #24 was admitted to the facility on a pureed diet and since they did not have access to ST they just accepted the previous facility's orders. She stated Resident #24's spouse requested a regular diet for her, so they obtained a food waiver from the family. Interview with the DOR on 09/03/20 at 10:21 a.m. revealed she did not work with Resident #24 on swallowing but had worked with her on range of motion to improve her ability to self-feed. She stated they have not had ST available since everything shut down due to COVID. She stated under normal circumstances the resident would have been followed by ST upon admission and would have been evaluated if the family or staff had requested an upgrade of her diet. She stated Resident #24 used to come to the dining room with the other residents who required feeding assistance, but her spouse did not want to come to the dining room and he requested that both of their meals be served in their room. Interview with the DON on 09/03/20 at 12:56 p.m. revealed she had been with the facility since April 2020. She stated under normal circumstances anytime a resident asked to upgrade their diet they would have ST evaluate them for safety, but since ST was not allowed into the building they obtained a waiver from the POA. When asked why they did not try a more gradual step up from pureed texture to mechanical soft texture, the DON stated they were just following the spouse's wishes. Interview with the Administrator on 09/03/20 at 1:12 p.m. revealed they had not had ST available since corporate locked down the building around the first of April (2020) due to COVID. The Administrator stated they had used two PRN (as needed) ST up until the end of March (2020). She stated when COVID hit, corporate told all PRN staff they had to select which building they would be dedicated to. She stated they did not have enough residents in need of speech therapy to keep a ST full time, so they did not have ST available since April (2020). She stated PT and OT were doing Telehealth meetings with their DOR to develop the therapy plan of care and their DOR who is a COTA and their full time PTA carry out those plans, but they have not been able to provide ST. She stated corporate had made the determination that PT, OT and ST were not essential visitors and could not come into the building. In an interview with the RDO on 09/03/20 at 1:24 p.m. he revealed when the first State Mandate was issued in March of 2020 to close all visitation to facility for all non-essential visitor into the building they determined that it was too risky to continue to allow PT, ST and OT to come in and out of multiple buildings. He stated they asked the therapy staff to pick which building they would be assigned to. He stated there was a notification sent out to the facilities that if a need arose for therapy they would evaluate to determine how they would be able to meet the resident's therapy needs. He stated the DOR should have sent a request to their regional office about the need for a ST evaluation for Resident #24. He stated there is a ST evaluation scheduled for the resident today (09/03/20). The facility has no policy for Therapy Evaluations. Review of the facility's policy titled, COVID-19 Novel Coronavirus dated 03/11/20, reflected, .The facility will restrict visitation of all visitor and non-essential health care personnel, except for end-of-life situations Visitors who provide critical assistance my include the following: Persons who provide essential services, such as those whose services are necessary to ensures resident health and safety .

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F 0825 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2)
F 0849 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain from hospice the most recent plan of care specific to each patient, the physician recertification and the hospice medication information specific to each patient for one (Residents #10) of one resident reviewed for hospice services. The facility failed to obtain Resident #10's most recent hospice plan of care, physician recertification and list of medications from the hospice provider. This failure placed residents at risk in services and treatments not being coordinated. Findings included: Review of Resident #10's Admission MDS, dated [DATE], reflected she was an [AGE] year-old-female admitted to the facility on [DATE] and [DIAGNOSES REDACTED]. (Gastric [MEDICAL CONDITION] Reflux Disorder) Review of Resident #10's medical chart revealed a Hospice Election form with the start of care on 06/29/20. Resident #10's chart reflected no Physician Certification of Terminal illness, Plan of Care, or medications list on file. . Interview with the DON on 09/02/20 at 10:30 AM revealed she did not know who the designated hospice coordinator for the facility was. In a subsequent interview with DON on 09/02/20 at 1:25 PM revealed she and the social worker were in charge of hospice. She stated she had just found out today (09/02/20). Interview with ADON H on 01/23/19 at 2:10 PM revealed she was not sure who was responsible for ensuring the hospice information was current and up to date . Review of the facility's policy, Hospice Services and Palliative Caredated 03/12, reflected, . Physician will complete (Palliative Care Form) .and Care Plans should be completed by the interdisciplinary Care Plan Team to clearly define the care and services the resident is to receive. The interdisciplinary team, including hospice personnel, will insure comfort measures are maintained for the resident and their families when end of life is near.