STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675939	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VINTAGE HEALTH CARE CENTER	205 N BONNIE BRAE DENTON, TX 76201

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 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 coordinate assessments with the pre-admission screening and resident review (PASRR) program to the maximum extent practicable to avoid duplicative testing and effort, which included incorporating the recommendations from the PASRR level II determination and the PASRR evaluation report into a resident's assessment, care planning and transitions of care for one (Resident #16) of six residents reviewed for PASRR assessments. The facility failed to provide specialized services to Resident #16 agreed upon during the IDT meeting on 12/16/19 and 03/10/20. This failure could affect residents by placing them at risk of their specialized needs not being met. Findings included: Resident #16's face sheet dated 03/13/20 reflected the [AGE] year-old male resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #16's admission MDS assessment dated [DATE] reflected he was indicated as PASRR positive with intellectual disability. The conditions related to ID/IDD status indicated ID/IDD with no organic condition. Her BIMS was 7 (indicating severely cognitive impaired). He was indicted for [MEDICAL CONDITION] with inattention and disorganized thinking which fluctuates. He required extensive assistance with one-person physical assist for dressing, walking, transferring, and toilet use. He requires total dependent for one staff for bathing. He has an impairment in range of motion to the lower extremities on one side. He uses a walker and wheelchair for ambulation. He received occupational therapy for five days for a duration of two hundred and forty minutes. The start date of the occupational therapy reflected 12/10/19. He received physical therapy for four days for a duration of 139 minutes. Resident #16's Care Plan with date initiated on 12/16/19 and revised on 02/04/20 indicated Resident #16 was PASRR positive due to intellectual disabilities. The LIDDA would meet with IDT and resident monthly to determine if any services are needed until next review. The intervention- facility IDT, LA representative, resident, family and the community group home representatives will have an initial care plan meeting to determine resident needs and set goals to safety discharge back to the group home in the community. The IDT and the LIDDA habilitation coordinator will have a specialized care plan meeting quarterly to determine if all needs of resident are being met. The LIDDA habilitation coordinator will meet with resident and staff monthly to evaluate for any needs. The LIDDA will complete PASRR evaluation. Resident #16's PASRR Comprehensive Service Plan (PCSP) Form reflected the initial IDT meeting was on 12/16/19. The form was rejected by the TMHP due to (Resident #16) identifying information not valid. The resident was positive for Intellectual Development Disability (IDD) only. Resident #16, DON, LA-IDD , Service Coordinator, SW, DOR, group home director, MDS Coordinator, and group home nurse attended the meeting. Specialized Services were indicated at that time for habilitation coordination and service coordination. Comments indicated it was an initial care plan meeting with facility IDT, the LIDDA and group home representative and Resident #16. The Facility IDT reported progress with rehabilitating his hip, and he was now able to ambulate with a walker. Currently he had a surgical wound infection, oral antibiotics and daily dressing changes. The Group home representative informed the facility that Resident #16 would have to be able to walk independently using his walker and to be able to get in and exit the group home van. Facility therapy was to do a home evaluation prior to Resident #16's discharge to see if modifications or safety features needed to be added prior to his discharge. PASRR services would include habilitation services, at least monthly. Review of the facility's Multidisciplinary Care Conference for Resident #16 on 12/19/19 at 3:00 p.m. revealed the following were at the conference: RN, SW, Nursing Administration, MDS Coordinator, and DOR present at the meeting. The report reflected: .J. Physician Summary b. Habilitation coordination for PASRR services for now. Therapy to do evaluation of group home for any renovations that may be needed. He needs to be walking independently with a walker, able to independently get in and exit the van. Signed by MDS Coordinator Attached was a LIDDA Signature Sheet indicating Habilitation Coordinator, DON, Resident #16, SW, DOR, group home director and group home nurse. Review of the Care Plan Conference Notes for Resident #16 on 03/10/20 reflected: Quarterly meeting with Resident #16 in attendance. IDT members were MDS Coordinator, SW, DOR, ADON, and MHMR Habilitation Coordinator. Meeting discussed nursing, social services, dietary services, activities and therapy . Review of Resident #16's Progress Notes reflected: 12/19/19 at 3:07 p.m. - Care plan meeting held today with Resident #16, MHMR, and 3 group home representatives. Resident #16 continue with rehab stay, meeting progress in therapy. 03/10/20 at 2:08 p.m. - Care plan meeting held today with Resident #16 and MHMR. Discussed Resident #16 status with nursing, progress with therapy, planned discharge date of [DATE]. On 03/11/20 at 2:58 p.m. an interview with the MDS Coordinator revealed she needed to resubmit the comprehensive service plan because the previous service plan submitted was rejected due to the wrong social security number entered. On 03/13/20 at 2:25 p.m. an interview with the MDS Coordinator revealed she did not resubmit the PASARR evaluation because she did not have time. She said she had been doing 3 new admissions and other things. On 03/13/20 at 2:45 p.m. an interview with the DON revealed there was no documentation of visits conducted by the LIDDA with Resident #16. She was unsure if the LIDDA visited but had attended the IDT and care plan meetings. She said Resident #16 should be receiving habilitation services once a month from the LIDDA. The SW did not communicate with the LIDDA after each visit to ensure services were coordinated. On 03/13/20 at 2:47 p.m. an interview with the SW revealed the only time the LIDDA had visited the facility was at the care plan meetings. She did not have any documentation or communication notes of any visits from the LIDDA for Resident #16. On 03/13/20 at 3:40 p.m. an interview with the LIDDA representative revealed Resident #16 should be receiving services but does not due to the service plan not being submitted in the long-term care (LTC) portal. The service plan must be uploaded, accepted, and alert the LIDDA for a visit. He had not conversed with Resident #16 to ensure what services were needed. He has only interacted with Resident #16 only at the care plan meeting on 12/29/29 and 03/10/20. He had made brief eye contact with the resident from a distance. He had not communicated with any staff during a visit and was unsure if staff were aware of his visits. He said he should be visiting with Resident #16 monthly for 15-30 minutes to provide services and check the status of Resident #16. On 03/13/20 at 2:50 p.m. the DON revealed the MDS Coordinator resubmitted the PASAR evaluation in the portal for Resident #16. On 03/13/20 at 4:05 p.m. an interview with the MDS Coordinator revealed she had printed out the resubmitted evaluation and it was again denied. Review of Resident #16's PASRR resubmission in the LTC portal on 03/13/20 revealed the form was rejected by the TMHP with the following error, Please correct the following: date of assessment cannot be more than 90 days prior to current date. Submitted by MDS Coordinator. Review of the facility's undated policy on Coordination- PASSR reflected: Policy It is the policy of the center to assure that all residents admitted to the center receive a Pre-Admission Screening and Resident Review, in accordance with state and federal regulations. Procedure 1. The center will coordinate assessments with the pre-admission screening and resident review (PASRR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. 2. Coordination includes: a. Incorporating the recommendations from the PASRR level II determination and the PASRR evaluation report into a resident's assessment, care planning, and transitions of care. b.

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 0644 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment .
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for three (Residents #74, #75 and #79) of three residents observed receiving blood glucose monitoring. Two nurses LVN A and LVN B were observed providing blood glucose monitoring. 1. LVN A failed to disinfect the glucose meter after glucose monitoring for Resident #75 and Resident #79. 2. LVN B failed to disinfect the glucose meter after glucose monitoring for Resident #74. These failures placed the residents receiving blood glucose at risk for cross-contamination, allowing for possible transmission of microorganisms, resulting in the development of infection. Findings included: 1 Observation on 03/12/20 at 11:05 a.m. revealed LVN A retrieved the glucose meter from the top of the medication cart and obtained a blood sample from Resident #75. After testing the sample and without disinfecting the meter, the nurse wiped the meter with a 70% alcohol prep pad and placed the meter on top of the medication cart. 2. Observation on 03/12/20 at 11:15 a.m. revealed LVN A retrieved a different glucose meter from the top of the medication cart and obtained a blood sample from Resident #79. After testing the sample and without disinfecting the meter, the nurse wiped the meter with a 70% alcohol pad. She then placed both meters into the top drawer of the medication cart. 3. Observation on 03/12/20 at 11:28 a.m. revealed LVN B retrieved the glucose meter from the top of the medication cart and obtained a blood sample from Resident #74. After testing the sample and without disinfecting the meter, the nurse wiped the meter with a 70% alcohol prep pad and placed the meter into the top drawer of the medication cart. Observation of the nurse's medication cart during this time revealed there were no sanitizing/disinfectant wipes on the cart. An interview with LVN B on 03/13/20 at 1:45 p.m. revealed he had used the alcohol wipe on the glucometer because he thought there were no disinfectant wipes available. He stated sometimes he used the disinfectant wipes and sometimes he used the alcohol pad. An interview with the DON on 03/12/20 at 2:25 p.m. revealed glucose meters used in the facility were not individually designated to residents. She stated the meters were community use meters and her expectations were meters would be disinfected with a sanitizing/disinfectant wipe after use and between residents. Observation on 03/13/20 at 10:15 a. m. with the DON revealed there were containers of Micro-Kill disinfectant wipes on the nurse's medication carts. Observation of the supply room with the DON on 03/13/20 at 2:55 p.m. revealed there was a full shelf of Micro-Kill disinfectant wipes. The DON stated the wipes were available on 03/12/20 when the nurses used alcohol to wipe the meters and she did not know why the nurses did not use them. She further stated she believed the nurses had a lack of knowledge about the proper way to disinfect the meters. On 03/13/20 the DON provided an in-service training related to sanitizing the glucometers and the facility's undated policy/procedure entitled Fingerstick Glucose Level and identified it as current. The policy/procedure reflected the glucometer should be cleaned with germicidal wipes or bleach and water solution diluted with a 1:9 ratio before initial use, after final use and between each resident following manufacturer recommendations. The glucose meter user's guide page 44 and 45 reflected cleaning and disinfecting the meter was very important in the prevention of infectious diseases. Validated disinfecting products included Micro-Kill disinfection wipes, Dispatch Hospital disinfectant towels with bleach and Clorox Healthcare bleach germicidal and disinfectant wipes. Review of the CDC website (https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html) on 03/18/18 revealed best practices for performing blood glucose monitoring in a licensed healthcare facility included: Whenever possible blood glucose meters should be assigned to an individual person and not be shared. If the meter must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions to prevent carry-over of blood and infectious agents.