STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS CEN	5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Initial Comments An unannounced facility reported incident/complaint survey was conducted at this facility from December 30, 2022 to January 12, 2023. Survey activities consisted of observations, record review, and resident and staff interviews. The facility's census during the survey was 237 and the sample included six (6) residents. Facility reported incident DC00011427 and Complaint DC00011462. Deficiencies were cited related to both investigations. After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 22B District of Columbia Municipal Regulations Chapter 32 requirements for Long Term Care Facilities. The following deficiencies are based on observation, record review, and resident and staff interviews. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility	L 000	Deanwood Rehabilitation and Wellness Center LLC makes its best efforts to operate in substantial compliance with both Federal and State laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the statement of the deficiencies. This plan of correction (POC) is prepared and/ or executed because it is required by State and Federal laws	

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

Jorge D. Raphael — Interim Administrator — 2/23/2023

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CRNP- Certified Registered Nurse Practitioner
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C- Discontinue
Dl- Deciliter
DMH - Department of Mental Health
DOH- Department of Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
F - Fahrenheit
FR.- French
G-tube- Gastrostomy tube
HR- Hour
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP- Infection Prevention and Control Program
LPN- Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
M- minute
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
N/C- nasal canula
Neuro - Neurological
NFPA - National Fire Protection Association
NP - Nurse Practitioner
O2- Oxygen
PASRR - Preadmission screen and Resident Review

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L 000	Continued From page 2 Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POA - Power of Attorney POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for	L 051	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Meal Preference for Resident# 2 was updated on 01/10/23 with the resident's dietary preferences to avoid gravy. Care plan for Resident #2 was updated to ensure meal preferences on 2.23.23 are followed. The resident did not have any negative outcome from the deficient practice. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. Food Services Manager or designee will audit menu preferences to ensure that residents are provided with food of their choice/preference. The audit will be completed no later than 2.21.23. Any negative issues will be corrected upon discovery.	

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L 051	Continued From page 3 direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on observation, record review and resident and staff interview, the facility failed to develop a care plan to with goals and approaches to address Resident #2's dietary preference (no gravy on food) for one (1) of six (6) sampled residents. The findings included: Review of the District of Columbia's complaint intake #DC00011462 submitted to the State Agency on 01/09/23 documented," ...my mother has endured ... "[Staff] ignoring dietary request ..." Resident #2 was admitted to the facility on 06/26/14. The resident had a history of multiple diagnoses including type 2 diabetes mellitus, morbid obesity, and hypertension. During an observation on 01/11/23, at approximately 10:30 AM, Resident #2 was sitting in her bed watching television. The resident was asked, how she liked the food served in the facility? She stated, "They put gravy on everything, and I've told the dietician (Employee #13) that I don't like gravy on my food several times. He said he would make dietary aware, but I keep getting gravy on my food. It just happened 2 days ago (01/09/23)."	L 051	**3. MEASURE TO PREVENT REOCURRENCE** Education was done by the Staff Educator/designee for the dietitians and Food service manager on 2.15.23 to ensure the residents preferences are followed as per the plan of care. **4. MONITORING CORRECTIVE ACTION** The Dietitian will audit resident's dietary preferences to ensure the resident's dietary preference is followed. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. Negative findings if any, will be corrected upon discovery. Date of Compliance: 02/24/2023	

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L 051	Continued From page 4 Review of the resident's medical record showed the following: 10/28/21 [Physician Order] instructed, "No added salt, consistent carbohydrate, regular texture, thin consistency diet ..." 12/17/22 [Quarterly Minimum Data Set] documented, Resident #2 had a Brief Interview for Mental Status summary score of "15" indicating the resident had an intact cognitive status. And the resident was coded for receiving a therapeutic diet. Resident #2's current and resolved care plans failed to address her preference not to have gravy added to her meals. A review of the resident's menu located in the facility's dietary department lacked documented evidence of the resident's preference to not have gravy on her food. During a face-to-face interview on 01/11/23, at approximately 2:00 PM, Employee #13 (Dietician) stated that he doesn't include residents' dietary preferences in their care plan. Because the resident's preferences are reflected on the resident's menu in the dietary department. During a face-to-face interview on 01/11/23 at approximately 3:00 PM, Employee #14 (Food Service Director) stated he was not aware that Resident #2 did not want gravy added to her foods. He said he would update her menu located in the dietary department to include her preference. The employee was asked if gravy was served on 01/09/23? He stated, "Yes".	L 051		

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L 052	Continued From page 5	L 052	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Employee#4 was terminated on 12/29/22. The details of Resident #1 were provided to the local authorities, police, Adult Protective Services, and the Detectives assigned to his case for the investigation. The facility continues to check with the detectives, local hospitals, and the resident's listed contact for updates. The Resident has not been located as of 2.23.23	
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist	L 052	**2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. A house-wide audit was done by the ADON from 12.29.22 till 2.15.23 and no other residents that went for appointments with escorts were affected and there were no incidents of elopement. **3. MEASURE TO PREVENT REOCURRENCE** Staff Educator will complete education for all escorts no later than 2.21.23 to ensure that they follow the protocols set for safely escorting residents on appointments. **4. MONITORING CORRECTIVE ACTION** An audit will be done by Medical Records/designee to check with the escort and resident if applicable, to ensure there was no lapse in supervision during the appointment. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. Negative findings if any, will be corrected upon discovery. Date of Compliance: 02/24/2023	

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him or her in eating independently;

(i)Assistance, if needed, with daily hygiene, including oral acre; and

j)Prompt response to an activated call bell or call for help.

This Statute is not met as evidenced by: Based on observation, record reviews, staff interviews, and interviews with staff at a local clinic, for two (2) of the six (6) sampled residents, the facility staff failed to ensure that sufficient nursing time was given to provide adequate supervision to Resident #1 during a staff-escorted visit to a local orthopedic clinic. Subsequently, Resident #1 eloped on 12/29/22 and had not been located by the close of this survey on 01/12/23; and failed to ensure that Resident #2 received incontinent care in a timely manner for one (1) resident. Residents' #1 and #2.

The findings included:

1.Facility staff failed to ensure that sufficient nursing time was given to provide adequate supervision to Resident #1 during a staff-escorted visit to a local orthopedic clinic. Subsequently, Resident #1 eloped on 12/29/22 and had not been located by the close of this survey on 01/12/23.

Resident #1 was admitted to the facility on 01/31/23 with multiple diagnoses including peripheral vascular disease, alcohol abuse, and a history of falling.

Review of DC Intake Form # DC00011427 submitted to the State Agency on 12/29/22 at

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6:46 PM documented, "Resident is 78 years old male who left the facility this AM [12/29/22] at about 8:00 AM for orthopedic appointment ...with escort [Employee #4's name]. Call received from [Employee #3] at about 1:00 PM [stating] that the resident left the clinic while the escort went to use the restroom ... [Employee #4] said he came outside looking for the resident, but he could not find the resident. 8 staff members [from the nursing home] ...immediately drove to the appointment address. [Conducted] a 20-block radius search ...Resident could not be found ...DC police department were notified at about 3:48 PM.

Review of the Resident #1's medical record the following:

Review of Resident #1's Quarterly Minimum Data Set dated 11/04/22 revealed the following:
Section C (Cognitive Patten) the resident had a Brief Interview for Mental Status summary score of "9" indicating Resident #1 had moderately impaired cognitive functioning.
Section E (Behavior) - the resident was not coded for rejection of care or wandering.
Section G (Functional Status) the resident was coded for requiring the supervision of one person for walking in the room, walking in the corridor, locomotion on the unit, and locomotion off the unit.
Section P (Restraints and Alarms) the resident was not coded for using restraints or alarms.

12/29/22 at 6:34 PM [Nursing Note] documented, "[Resident #1] ... left the facility this AM at about 8:00 AM for orthopedic appointment ... with escort [Employee #4, Certified Nursing Assistant] ... Call received from [Employee #4] at about 1:00 PM that [Resident #1] left [orthopedic] clinic while

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[Employee #4] went to use the restroom ... [Employee #4] reported that when he came out of the restroom, he could not find the resident ... [Employee #4] said he [went] outside to looking for the [Resident #1], but could not find [him] ..."

12/29/22 at 7:35 PM [Social Worker's Note] documented, " ... [Two Detectives names listed] have been assigned to this case from the Missing's Person's Division ... the incident number is 22-189-228.

12/30/22 [Situation, Background, Assessment, and Request Form] documented, "Resident left the doctor's office after [an] orthopedic appointment while the escort was in the restroom ...[on] 12/29/22 ...The escort reported that when he came out of the restroom, he could not find the resident ..." It should be noted that this document had an effective date of 12/29/22 at 4:35 PM.

12/30/22 at 10:50 PM [Social Worker's Note] documented, " ... [Detective's name] ...shared that upon his visit to the [orthopedic clinic] front desk attendant ...shares that [Employee #4] was previously sleeping and was using their desk phone to call [facility's] transportation ...[Resident #1] created a follow-up appointment ... then proceeded to walk out of the office ...[Employee #4] yelled, "hey, hey" twice to [resident's name] ... [Employee #4] quickly abandoned the effort [to locate the resident] and returned [to the orthopedic office] to call for transportation ... [Employee #4 left] when transportation arrived ...The detective also shared that he followed up with [Employee #4] and informed him that he knew that he was being dishonest about his claim of using the restroom when the resident eloped ..."

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L 052	Continued From page 9 01/04/23 at 5:12 PM [Social Worker's Note] documented, " ...[Detective's name] ... stated that has requested for social workers at the Department of Human Services to check the local shelters ... in addition, officers have been calling hospitals daily ... This social worker shared with [detective] that she and a group of staff members have canvased Washington DC on 01/04/23 in an effort to locate [resident's name] ... [Detective's name] also shared that will be making referrals to APS [Adult Protective Services] and the governing body that houses [Employee #4's] certified nursing assistant license ..." 01/06/23 at 4:14 PM [Social Worker's Note] documented, "This social worker spoke with [detective's name] at 3:29 PM. He shared that the Metropolitan Police Department has yet to find [resident's name]. He shared that APS informed him that [Employee #4] being terminated is sufficient action to satisfy any investigation they would conduct. He also shared that he filed a formal compliant with DOH [Department of Health] Board of Nursing against [Employee #4] ... He shared that his contact a DHS (Department of Human Services) stated that [Resident #1] has not signed into any shelters, and the morgue has not reported anyone matching his description ... DHS has passed out flyers to all of the men's shelters in the District." 1/12/23 at 10:03 PM [Social Worker's Note] documented, "This social worker spoke with [detective' name]. The detective asked this social worker for a dental consult of [resident's name]. The social worker provided him the assessment via email."	L 052		

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Review of Resident #1's current and resolved care plans lacked documented evidence the resident was an elopement risk or wander from 02/02/22 to 12/28/22.

Review of the facility's investigation notes revealed the following:
12/29/22 at 11:00 AM [Employee #5's (Driver) written statement] documented," On 12/29/22 I took [resident's name out to an appointment ...along with has (sp) escort [Employee #4's name] After dropping [resident's name and Employee #4's name] off at his appointment. A hour later [Employee #4's name] called and [said] he was [ready to be picked up]. After [Employee #4's name] got on the bus. I asked him [where] was you client [resident] at and he [said] he walked away from him, he and I then roded (sp) around looking for him, and we couldn't find him.

12/29/22 at 2:15 PM [Employee #4's written statement] documented, "I was on escort with [resident's name] at [orthopedic clinic's name]. After his consultation we sat at the waiting room of the clinic waiting for driver [transportation] ... to come take us back. I went to the restroom ... but on returning I didn't find the resident. The receptionist told me he just stepped out. I went out and searched around the building but couldn't find him. I called Deanwood to report it, but it fell on the answering machine. The driver came at about 1:30 PM and we left for [Deanwood].

Review of administrative record Employee #4's personnel file revealed the employee received new-hire orientation training on 06/02/22 that included an in-service titled, "Resident Safety while on Medical Appointment". The employee scored 100 percent on the post-test. Review of the teaching material included a memorandum

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dated 01/26/22 from the Transportation Director that instructed escorts, " ... never to leave the resident un-attended. If you must go to the restroom, ask the nurse or attendant if they can keep an eye on the resident for you. You cannot under any circumstance leave the resident alone ..."

During a face-to-face interview on 12/30/22 at approximately 5:30 PM, Employee #2 (Previous DON) stated that Employee #4 was terminated following the elopement incident because he should never have left the resident unattended. And after speaking with the police and clinic staff, they determined that the employee was not honest about what happened when the resident eloped.

During a face-to-face interview on 01/03/23 at approximately 11:15 AM, Employee #5 (Driver/Transportation) stated that an hour after he dropped Resident #1 and Employee #4 to the clinic, Employee #4 called him to tell him he was ready to be picked up. Employee #5 said that when Employee #4 boarded the bus he noticed the resident was not with him, so he asked where the resident was. Employee #4 told him the resident had walked away. After he was informed the resident had walked away, they drove around the area looking for the resident, but they could not find him. Employee #5 stated that they left the area to pick up another resident. However, they returned to the area to look for Resident #1 again after being instructed to do so by his supervisor (Employee #6). They were still not able to find the resident, so they drove back to the facility. After returning to the facility, he picked up eight employees and took them to the clinic to continue looking for the resident.

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	HFD02-0017	A. BUILDING: _____ B. WING _____	C 01/12/2023

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DEANWOOD REHABILITATION AND WELLNESS CEN	5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019

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L 052	Continued From page 12	L 052		

During a telephone interview on 01/03/22 starting at 3:47 PM, Employee #4 stated that he took Resident #1 to an orthopedic appointment on 12/29/22. The employee said after the resident was seen by the staff, the resident was sitting in the lobby, so he went to the bathroom. And when he came back to the lobby, he saw the resident "rushing out the door". He then ran after the resident and told him to come back but the resident refused. Employee #4 was asked did he physically try to stop the resident? The employee stated, "No, I was told in a training not to touch residents when they refuse and not to force them." Employee #4 was also asked did he ask the clinic staff to keep an eye on the resident while he went to the bathroom? The employee said, "No, I told the resident." Additionally, the employee stated, "I called the facility and got the answering machine. I left a message" about the resident "walking away" and then he called the driver and told him "I can't find my patient come quickly."

During a face-to-face interview on 01/09/23 at 1:56 PM, clinic staff stated that the aide (Employee #4) slept and was on the phone while the resident was in the office. Clinic staff stated that the resident left the office after he made his follow-up appointment. Clinic staff was asked where was the aide when the resident made his follow-up appointment? She said that he was using the desk phone. Following the resident's exit, the aide ran behind him and returned to the office five minutes later without the resident. Clinic staff said that when the aide returned, he did not tell them that the resident had walked away. As he waited for transportation to arrive, the aide fell asleep in the lobby for approximately 40 minutes before he was picked up. When asked if the aide used the bathroom while he was

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L 052	Continued From page 13 in the clinic? She said, "No." There was no evidence that facility staff provided adequate supervision for a Resident #1 during a staff-escorted visit to a local orthopedic clinic appointment. 2. Facility failed to ensure that sufficient nursing time was given for Resident #2 to receive incontinent care in a timely manner. Resident #2 was admitted to the facility on 06/26/14. The resident had a history of multiple diagnoses including type 2 diabetes mellitus, morbid obesity, chronic pain, and major depression. Review of the District of Columbia's complaint intake #DC00011462 documented," ...my mother has endured ... being left uncleaned for multiple instances of 12 + hours or more .... " During an observation on 01/10/23 around 11:00 AM. Resident #2 was seen brushing her teeth while sitting in bed. The resident was asked how did she like the care provided by staff? She stated that staff take a long to provide incontinent care when she has a bowel movement. When asked if she could remember when that happened? She stated, "It happens all the time. Yesterday (01/09/22), I had to wait 2 hours and 15 minutes to be changes. I told them at 9:15 AM and they came at 11:30 AM." When asked if she had to wait longer than 2 hours and 15 minutes prior to 01/09/22? Resident stated, "Yes, I waited overnight one time, but I can't remember the date." Review of the Resident #2's medical record	L 052		

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revealed the following:

07/19/22 [physician order] instructed, "Incontinent care by 2 persons every shift."

11/13/22 (revision date) Care Plans documented: Focus area- [Resident's name] had bladder and bowel incontinence r/t (related to uncontrol urges, morbid obesity and physical limitations. Interventions: Check the resident every 2 hours and as required for incontinence. [Resident's name] cannot participate in toileting and requires total assistance with incontinence care/management at this time ..."

Focus area - [Resident's name] has an ADL (activity of daily living) self-care performance deficit r/t (related to) limited ROM (range of motion), limited mobility, morbid obesity and she is a 2 person assist. Interventions- 2 staff to sign ADL form, [Resident's name] most (sp) be assisted by 2 persons at all times ..."

12/17/22 [Quarterly Minimum Data Set] documented, Resident #2 had a Brief Interview for Mental Status summary score of "15" indicating the resident had an intact cognitive status. The resident was coded for frequently incontinent of stool, always incontinent of urine, and being totally dependent of two or staff members for toilet use.

01/09/23 [Resident Care Monitoring] Log documented that incontinent care was provided at 10:40 AM.

During a face-to-face interview on 01/10/23 at approximately 11:30 AM, Employee #10 (Certified Nursing Assistant - CNA) reported that the resident informed her around 8:30 AM that she

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L 052	Continued From page 15 needed incontinent care. According to the employee, she did not provide care at 8:30 AM because she had to feed residents, prepare two residents for dialysis, and wait until another certified nursing assistant could assist her. Employee #10 then reported that she provided incontinent care a few hours later. During a face-to-face interview on 01/10/22 at 12:15 PM, Employee #11 (Unit Manager) stated that she was made aware of the delay in staff providing incontinent care. According to her, she asked the certified nursing assistant why it took 2 hours to provide incontinent care for Resident #2. She was told by the certified nursing assistant that she had to feed residents, prepare two residents for dialysis, and wait for another nursing assistant to assist Resident #2. Employee #11 was asked which was the highest priority for her staff, changing an incontinent resident or making sure a resident was ready for dialysis. She said, "Get residents ready for dialysis".	L 052		
L 201	3231.12 Nursing Facilities Each medical record shall include the following information: (a)The resident's name,age, sex, date of birth, race, martial status home address, telephone number, and religion; (b)Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor; (c)Medicaid, Medicare and health insurance numbers;	L 201	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** The MDS for resident#2 was corrected on 1.13.23 and coded for obvious or likely cavity or broken natural teeth. No negative outcomes were noted from this deficient practice. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All current residents have the potential to be affected. A house wide audit will be done by the Director of Nursing/designee no later than 2.21.23 for all MDS completed from 9.19.22 to 2.15.23 to ensure that current residents with broken teeth/cavity were coded correctly. Any negative findings will be corrected upon discovery.	

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L 201	Continued From page 16 (d)Social security and other entitlement numbers; (e)Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses; (f)Date of discharge, and condition on discharge; (g)Hospital discharge summaries or a transfer form from the attending physician; (h)Medical history and allergies; (i)Descriptions of physical examination, diagnosis and prognosis; (j)Rehabilitation potential; (k)Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease; (l)Current status of resident's condition; (m)Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo condition; (n)The resident's medical experience upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged;	L 201	**3. MEASURE TO PREVENT REOCURRENCE** Education was done on 2.15.23 for the MDS coordinator by the MDS Director to ensure that the MDS coding reflects the resident's Dental status correctly. **4. MONITORING CORRECTIVE ACTION** An audit will be done by the Director of Nursing/designee to ensure that MDS is coded accurately to reflect the resident's current dental status. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. Negative findings if any, will be corrected upon discovery. Date of Compliance: 02/24/2023	

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L 201	Continued From page 17 (o)Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service; (p)A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services; (q)The plan of care; (r)Consent forms and advance directives; and (s)A current inventory of the resident's personal clothing, belongings and valuables. This Statute is not met as evidenced by: Based on record review and staff interviews, facility staff failed to ensure that Resident #2's Minimum Data Set (MDS) assessment was coded to reflect her current dental status at the time of the assessment for one (1) of six (6) sampled residents. The findings included: Resident #2 was admitted to the facility on 06/26/14. The resident had a history of multiple diagnoses including type 2 diabetes mellitus, morbid obesity, and hypertension. Review of the Dental Consult dated 04/06/22 documented, " ... fractured ...[teeth] #19, #20, and # 30 ...pt (patient) referral to [hospital's name] for treatment."	L 201		

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L 201	Continued From page 18 Review of Resident #2's Annual MDS dated 05/05/22 documented, "The resident had a Brief Interview for Mental Status summary score of "15" indicating that the resident had an intact cognitive status. The resident was also coded for obvious or likely cavity or broken natural teeth. Review of the resident's Quarterly MDS dated 09/19/22 revealed the resident was not coded for dental issues including broken teeth. During a face-to-face interview on 01/12/22 at 2:05 PM, Employee #7 (MDS Director) stated that if the resident had broken teeth at the time of the assessment on 09/19/22, it should have been recorded. He then said he would assess the resident and correct the MDS.	L 201		