STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415084	A. BUILDING _____ B. WING _____	**05/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELMHURST REHABILITATION & HEALTHCARE CENTER	**50 MAUDE STREET PROVIDENCE, RI 02908**

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 0641 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it has been determined the facility failed to accurately assess a resident in the Minimum Data Set (MDS), reflective of the resident's status at the time of the assessment, relative to one of three sample residents, ID #1. Findings are as follows: Record review of Resident ID #1 revealed a primary [DIAGNOSES REDACTED]. Review of the initial MDS assessment dated [DATE] for Resident ID #1 revealed impairment to range of motion on both the upper and lower extremities on one side of the body. A care plan dated 10/02/2019 for Resident ID #1 stated in part; . history [MEDICAL CONDITION]/ L sided [MEDICAL CONDITIONS], and dysphagia . with appropriate interventions and goals. Subsequent MDS assessments dated 12/26/2019, 02/17/2020 and 05/17/2020 fail to reflect any impairment to range of motion. During an interview 06/04/2020 at 3:26 PM the MDS nurse responsible for Resident ID #1 acknowledged the MDS assessments on 12/26/2019, 02/17/2020 and 05/17/2020 were inaccurate.

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.