STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335775	A. BUILDING _____ B. WING _____	09/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRONX GARDENS REHABILITATION AND NURSING CENTER	2175 QUARRY RD BRONX, NY 10457

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** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview conducted during the recertification survey, the facility did not ensure that the assessment accurately reflected the resident's status. Specifically, the resident's dental status reflected on the Minimum Data Set (MDS) did not include broken and carious teeth. This was evident of 1 out of 1 resident reviewed for Dental Care out of a sample of 38 residents (Resident #435). The finding is: The facility policy titled Processing of Consultation policy dated 8/22/10 and last reviewed dated 9/18/20 documented under the section titled policy All residents will receive consultant services per written request of attending Physician. These services are provided in the Nursing Home except in circumstances where needed equipment to render service is not available in the Nursing Home. The facility policy titled MDS 3.0 dated 12/94 and last reviewed 3/2020 documented under the section titled Purpose: the facility shall conduct initial and periodical assessments that are accurate, standardized and reproducible for all its residents. The policy further states The Resident assessment Instrument (RAI) is the catalyst to the accurate assessment of each nursing home resident. Resident #435 was admitted to the facility with [DIAGNOSES REDACTED]. The Admission Minimum Set Data ((MDS) dated [DATE] documented the resident was cognitively intact. The MDS further documented the resident had no dental concerns in the section for Oral/Dental Status (Section L). The Comprehensive Care Plan titled Dental Care: Actual Impairment dated 7/30/2020 documented the resident had some teeth. On 09/28/20 at 10:54 AM, the resident was observed sitting in wheelchair in their room. Some of the resident's teeth were protruding from the mouth, and they had brown and dark areas. The resident denied any pain. On 09/29/20 at 08:54 AM, the resident was interviewed and denied any issues with eating regular food or mouth pain. The Speech Therapy Progress note dated 7/31/2020 documented a speech and swallow assessment was completed. The note documented the resident lacked dentition but was able to masticate regular foods without difficulty. A Dietary progress note dated 7/31/2020 documented the resident was seen for an initial assessment. The dietician documented the resident had poor dentition but denied chewing and swallowing issues. The Nursing Admission/Re-assessment dated [DATE] documented under the section titled Review of systems with subgroup heading General oral screening' documented Dentitions (has some /all teeth). A Medical progress note dated 8/3/2020 documented the resident had periodontal disease and a Dental consult was ordered. The Dental consult dated 8/4/2020 documented no dentures or removable bridge, some/all-natural teeth lost. Does not have or did not use dentures or partial plate. Broken loose or carious teeth. Oral hygiene fair. No mouth odor. Patient functional with present oral condition, soft tissue within normal limits. New admission soft tissue within normal limits, mostly edentulous with remaining teeth in poor condition. On 09/29/20 at 11:36 AM an interview was conducted with Staff # 1, Clinical Reimbursement Manager (CRM). The CRM stated she is an MDS Assessor and completes MDS assessments for the facility. CRM stated before she completes the MDS, she sees the resident and reviews the chart, which includes reading all the progress notes and consults. The dental consult was not in the resident's chart at the time of review. It had not been uploaded by the Medical Clerk yet. Even though the consult was completed 8/4/2020, it was not uploaded until 8/13/2020. The CRM stated she assumed the dental consult would be completed within the first 30 days of admission, and she did not think that the consult would be completed within the first eight days. The CRM stated she did not ask any staff if the consult was completed, and she based her completion of the MDS on the Nursing Admission Assessment. She saw the resident before completing the MDS and was aware the resident had crooked teeth, but she did not ask the resident to open their mouth, therefore she was unable to see if the resident had cavities inside the mouth. The CRM added the MDS will be modified to include the resident has broken or carious teeth. On 09/29/20 at 11:54 AM, an interview was conducted with Staff #2, Director of Clinical Reimbursement (DCR). The DCR stated she is responsible for monitoring the MDS Assessors and ensuring the assessments are completely accurately and on time. The DCR stated all the assessors sign-off on the completed books to confirm that they are accurate. The DCR stated she monitors the Assessors for completion and accuracy by reviewing the assessment and sign-off once the MDS book is completed. The DCR stated the MDS Assessor reported the dental consult was uploaded late in the system on 8/13/20 after the resident's ARD, so the consult was not available for review. The DCR added the MDS will be modified to reflect the resident status. On 09/30/20 at 11:12 AM, an interview was conducted with the Director of Nursing (DON). DON stated MDS assessment accuracy has not been identified as an issue previously. When completing the dental section, MDS assessors look for dental consults. Consultants have a list of residents to see, and when they complete the assessment it is handed off to the clerk in the nursing office within a day or two for filing and upload. 415.11(b)

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