STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335638	A. BUILDING _____ B. WING _____	**07/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BUFFALO CENTER FOR REHABILITATION AND NURSING	**1014 DELAWARE AVE BUFFALO, NY 14209**

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during an Abbreviated Survey (Complaint #NY 761) completed on 7/1/20 the facility did not ensure that each resident received treatment and care based on the comprehensive assessment of the resident that is in accordance with professional standards of practice for one (Resident #1) of three reviewed for quality of care. Specifically, there was a delay in obtaining a urine sample per the physician orders [REDACTED]. The finding is: The policy and procedure (P&P) titled Urinary Tract Infection revised on 12/2019 documented it is facility policy to provide the highest quality of care using the most up to date clinical standards. This includes but is not limited to preventing and treating urinary tract infections [MEDICAL CONDITION]. The procedure documented it is the responsibility of the interdisciplinary team to maintain vigilant practices to prevent UTI's. Resident #1 was admitted with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS- a resident assessment tool) dated 5/5/20, documented the resident had moderate cognitive impairment. The resident was assessed as being totally dependent with two-person physical assist for toilet use and transfers. Review of the hospital Discharge Summary dated 3/24/20 revealed the resident was hospitalized from [DATE] until 3/24/20 for [DIAGNOSES REDACTED]. Review of the Comprehensive Care Plan, dated as initiated on 3/30/20, documented the resident had [DIAGNOSES REDACTED]. Interventions included monitoring lab values. Review of physician's orders [REDACTED]. Review of Licensed Practical Nurse (LPN) #2 progress note dated 5/1/2020 at 9:25 PM documented the order and that the urine sample was unable to be obtained. Review of the urinalysis culture and sensitivity results dated as collected on 5/8/20 at 12:00 PM and received on 5/8/20 at 10:25 PM documented Resident #1's urine was positive ESBL and the results were reported to the facility on [DATE] at 5:25 PM. Review of physician orders [REDACTED]. The family called and told staff the resident seemed more confused and the physician ordered a urinalysis and chest x-ray. She stated the order for the U/A and C&S was only good for 24 hours and the physician should have been notified to re-order the sample. During a telephone interview on 6/8/20 at 10:10 AM, Licensed Practical Nurse (LPN) Unit Manager #2, she stated she discovered the urinalysis was not done when she looked for the results. She stated she was told by staff that the urine could not be obtained, even with straight catheter, due to the resident not producing urine. LPN #2 stated the Nursing Supervisor, and the physician should have been notified and a new order written. During a telephone interview on 6/10/20 at 1:46 PM, the physician stated the urinalysis was ordered because the family was concerned with the resident's mental status as the resident seemed more confused. He stated the resident had several medical issues including COVID-19 and was not eating. He stated he should have been called when the sample was not obtained on 5/1/20 and he would have re-ordered the urinalysis. He stated the UTI was treated at the time the results were available. During an additional interview on 6/30/20 at 9:45 AM, LPN Unit Manager #2, stated LPN #2 should have reported that he could not obtain the urine sample to the Nursing Supervisor and to the next shift coming on. The order was only good for 24 hours and when LPN #2 clicked on the order in the computer and charted it was not obtained, it canceled the order. She stated on 5/5/20 she was looking for the urinalysis results and found there were no results. She called the lab and found out that the sample was never received at the lab. During a telephone interview on 6/30/20 at 11:50 AM, Registered Nurse (RN) Supervisor #1 stated she does not remember LPN #2 telling her anything about the resident. RN #1 stated if she had known that a urine sample was not obtained, she would have tried to do a straight catherization to obtain the urine. If the catheterization did not result in a sample, she would have notified the physician. She stated she should have been informed, and the next shift should have been informed about the inability to get the sample. 415.12

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.