

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  405029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/23/2024
NAME OF PROVIDER OR SUPPLIER  Servicios Integrados DE Rehabilitacion (Siro) Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  Calle 4-L-10 Urb Colinas Del Oeste Hormigueros, PR 00660	

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)
<p>F 0584</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>47384</p> <p>Based on observations of the physical environment, review of policies procedures and facility staff interview performed on 04/22/2024 through 04/23/2024 to from 8:00 AM through 5:30 PM, it was determined that the facility failed to promote the resident right to receive services in a safe, clean, comfortable, and homelike environment. This deficient practice had the potential to affect 18 out of 18 residents receiving services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During observational tour at approximately 10:50 AM of April 22, 2024, it was observed that the weight in the shower area had rust in the base and other parts.</li> <li>2. During observational tour at approximately 11:00 AM of April 22, 2024, it was observed that the wheelchair weight in the Recreational Therapy was found with excessive dust.</li> <li>3. During observational tour at approximately 11:25 AM of April 22, 2024, it was observed that the grab bar on shower area was loose presenting a risk to patients taking a shower.</li> </ol>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 15884</p> <p>Based on records reviewed (RR) and interview with the Minimum Data Set- MDS coordinator (employee #1) it was identified that the facility failed to transmit as required, MDS (Minimum Data Set) with review of health data and resident status in 1 out of 1 MDS record over 120 days old.</p> <p>Findings include:</p> <p>RR#11 is a [AGE] year-old female resident admitted [DATE] with a diagnosis of Right Hip Replacement. The resident admission was on 10/22/2023 and discharge home was on 11/01/2023.</p> <p>On 04/23/2024 at 10:35 AM in an interview with MDS Coordinator (employee #1) it was identified that the MDS discharge data was not transmitted when finished because of lack of assessment data of the physical therapy personnel. The case remain open and that is the reason why the case appears with an MDS record over 120 days old. She explains that the case must be coded and transmitted as an admission and as discharge both before being transmitted and this was not performed.</p> <p>MDS coding was corrected on 04/23/2024 and transmitted with the correction. Resident assessment validation and entry system report was reviewed</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 20423</p> <p>Based on an interview with the Minimum Data Set- (MDS) coordinator (employee #1), it was determined that the facility failed to accurately electronically transmit resident assessment instrument status correctly in 1 out of 2 closed records reviewed (RR). (Resident #2)</p> <p>Findings include:</p> <p>During the records reviewed the electronic system identified resident #2 as a hospitalization .</p> <p>On 04/23/24 at 1:30 PM during the record review it was found that Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of Status post-surgery of Lumbar stenosis, in the record appears that resident #2 was a planned Discharge Home to the community due to completing goal and was discharged on [DATE] with appointment with primary physician and surgeon for follow up and continue treatment with home care for Physical Therapy Services for 10 days and Nursing Services for wound care.</p> <p>The MDS coordinator employee #1 interviewed on 04/23/2024 at 01:40 PM refer that this resident was discharged to the community, however when the information was enter to the system was document by error short-term general hospital. On 4/23/2024 at 3:01 PM she corrects this error and was transmitted correctly and accepted.</p>

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<p>F 0801</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>47384</p> <p>Based on observations and interview with the TSA (employee #2) performed from 04/22/2024 thru 04/23/2024, from 8:20 AM thru 4:30 PM, it was determined that the facility failed to provide a designated a person to serve as the director of food and nutrition services. This deficient practice had the potential to affect 18 admitted residents.</p> <p>Findings include:</p> <p>During interview with the TSA performed on 04/22/2024 she stated that the facility did not have Diet Department Manager. During survey on 04/23/2024 surveyors were notified that TSA (employee #2) was a designated as the Diet Department Manager.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>15884</p> <p>Based on observations of the Kitchen, review of policies procedures and facility staff interview performed on 04/22/2024 through 04/23/2024 to from 8:00 AM through 4:00 PM, it was determined that the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety.</p> <p>Findings include:</p> <p>During observational tour of kitchen on April 22, 2024, approximately at 8:52 AM, products such as cheese and meat were found unlabeled on the refrigerator.</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47384</p> <p>Based on observations of the physical environment, review of policies procedures and facility staff interview performed on 04/22/2024 through 04/23/2024 to from 8:00 AM through 5:00 PM, it was determined that the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. This deficient practice had the potential to affect 18 out of 18 residents receiving services at areas where the deficient environment and items.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. room [ROOM NUMBER] was observed detached from the wall behind bed and in bathroom.</li> <li>2. Towel rack on room was found loose from the wall.</li> <li>3. Chipped Formica was found chipped in most of the facility' rooms as detailed: <ul style="list-style-type: none"> <li>111 Bathroom door with chipped panel near doorknob</li> <li>110 Chipped Formica on closets</li> <li>109 Chipped Formica on night tables</li> <li>108 Chipped Formica on night tables and closet of resident A and B</li> <li>107 Chipped Formica on night tables and closet of resident A and B</li> <li>106 Chipped Formica on night tables and closet of resident A and B</li> <li>105. Chipped Formica on night tables and closet of resident A and B. Glue was observed on side of closet A</li> <li>104. Chipped Formica on night tables and closet of resident A and B. Hinges on closets in need of repair</li> <li>103. Chipped Formica on night table resident A</li> <li>102. Chipped Formica on Closet A</li> <li>101. Chipped Formica on closet resident B and night tables of resident A and B</li> </ul> </li> </ol>		