STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315485	A. BUILDING _____ B. WING _____	C 07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT WALL	**2621 HIGHWAY 138 WALL, NJ 07719**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS COMPLAINT #: NJ120090 CENSUS: 101 SAMPLE SIZE: 4	F 000		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance	F 842		8/28/19

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

Electronically Signed | 08/28/2019

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.

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F 842	Continued From page 1 with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint : NJ 120090 Based on interviews, review of the medical record	F 842	F 842 PLAN OF CORRECTION Medical Records	

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F 842	Continued From page 2 (MR) and other facility documentation, it was determined that facility staff failed to document in the MR, the [redacted] used after a [redacted] application, and failed to document that [redacted] care was performed for 1 of 4 sampled residents (Resident #3) according to standards of nursing practice and facility policy and protocol. This deficient practice is evidenced by the following; 1. According to the "Admission Record", Resident #3 was admitted to the facility in [redacted] with diagnoses which included but were not limited to; [redacted]. A Care Plan (CP), initiated [redacted] revealed at risk for skin alteration related to decreased mobility and use of [redacted] related to inability to turn without much difficulty due to [redacted]. Interventions included but were not limited to; [redacted] per physician order, Report signs of [redacted] infections such as [redacted] or complaints of [redacted]. A Physician's Order (PO), dated [redacted], indicated '[redacted] Care Q (every) shift". A Skilled Nursing Note by the Registered Nurse (RN) Supervisor (RN #1) on [redacted] at 7:49 a.m. revealed that the [redacted] was intact however, dislodged at 4:00 a.m. and a "new one reapplied connected to [redacted] bag..." There was no documentation of what size of [redacted] was applied. Review of a statement, dated [redacted] from RN #1, emailed to the New Jersey Department of	F 842	The facility failed to document in the medical record, the size of [redacted] used after a [redacted] application, and failed to document that [redacted] care was performed one occurrence out of 12 opportunities. Completion Date: 8/20/19 Resident #3 What corrective action (s) will be accomplished for those residents affected by the deficient practice.Completion Date: 7/31/19 The DON reviewed the patient's medical record. The [redacted] was removed prior to patient discharge. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Completion Date : 7/31/19 The DON, and the Unit Managers conducted a review of the medical records and no other patient were affected. What systemic measures will be put into place or what systemic changes made to ensure that the deficient practice will not recur. Completion Date: 8/1/19 The Unit Managers and nursing supervisors in-serviced nurses in r/t [redacted] care, and documentation including but not limited to assessment data during the procedure, size of [redacted], and if the patient tolerated the procedure.	

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F 842	Continued From page 3 Health (NJ DOH) from the Director of Nursing (DON), revealed that a [redacted] was used when reapplied on [redacted]. Review of a facility 2/2019 Certified Nurse's Aide "Tasks" sheet included "[redacted] Care every shift and as needed." The "Tasks" sheet indicated to document a "Y" for "Yes" if [redacted] care was provided. For 1 of 12 opportunities from [redacted] through [redacted] there was no documentation from staff on [redacted] for the 7-3 shift, that catheter care was provided. Review of a statement dated [redacted] from Licensed Practical Nurse LPN #1, emailed to the NJ DOH from the DON on 7/31/2019, revealed that LPN #1 "checked and assessed" the catheter on 2/1/2019 and noted it to be intact. During a post survey telephone interview with the surveyor on 8/6/2019 at 12:30 p.m., the DON confirmed that RN #1 should have documented the size of the [redacted] applied on [redacted] in the PNs. In addition, the DON stated that nurses or CNAs were to document/initial on the "Tasks" sheet to indicate care was completed. Review of a facility policy titled "[redacted]"), and dated "Revised October 2010" included but was not limited to the following; "...Documentation The following information should be recorded in the resident's medical record:...6. The size of the [redacted] used...." NJAC 8:39-27.1	F 842	The Unit Manager and Nursing Supervisors in-serviced certified nursing assistants in r/t [redacted] care documentation, and also educated them to initial the task once completed. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, i.e. what quality assurance program will be put into place to monitor the continued effectiveness of the systemic changes. Completion Date: 8/20/19 The DON and/or designee will audit up to two medical records related to documentation of [redacted] care and orders for the [redacted]. Results of the audit will be reviewed by nursing leadership at the Quality Assurance Committee monthly for three months to ensure compliance.	