STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315229	A. BUILDING _____ B. WING _____	C 08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX CENTER FOR REHABILITATION AND PEDIATRICS	1433 RINGWOOD AVE HASKELL, NJ 07420

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F 000	INITIAL COMMENTS STANDARD SURVEY: 08/27/2019 Complaint: NJ00126250, NJ00123218, NJ00126390 CENSUS: 176 SAMPLE SIZE: 35 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by	F 640		9/30/19

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

Electronically Signed | 09/19/2019

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F 640	Continued From page 1 CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set - Discharge Assessment in accordance with federal guidelines. This deficient practice was identified for 2 of 7 residents (Resident #1, #2) reviewed for resident discharge assessments. This deficient practice was evidenced by: 1.) On 8/21/19 at 1:55 PM, the surveyor reviewed Resident #1's electronic medical record. The	F 640	1.Discharge Assessment MDS for Resident #1 was completed on [redacted] and Resident #2 was completed on [redacted]. There were no negative outcome for both residents. 2. MDS Coordinator reviewed all residents who were discharged from the facility within the last 180 days to check if Discharge MDS Assessment were completed timely. All Discharge Assessment MDS for these residents were completed in a timely manner.	

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F 640	Continued From page 2 record revealed that the resident was admitted to the facility on [redacted] with diagnoses that included [redacted]. Further review of the record revealed that the resident was discharged to the community on [redacted]. The surveyor reviewed the Minimum Data Set (MDS) 3.0 assessment history, including all the completed MDS's for the resident. The MDS assessment history revealed that there was no Discharge Assessment MDS completed for the resident's discharge date of [redacted]. 2.) On 8/21/19 at 2:05 PM, the surveyor reviewed Resident #2's electronic medical record. The record revealed that the resident was admitted to the facility on [redacted] with diagnoses that included [redacted]. Further review of the record revealed that the resident was discharged to the community on [redacted] The MDS assessment history revealed that the Discharge Assessment MDS was not completed until [redacted]. According to the latest version of the Center for Medicare/Medicaid Services (CMS) - Resident Assessment Instrument (RAI) 3.0 Manual (updated October 2018) page 2-11 "Discharge refers to the date a resident leaves the facility. There are two types of OBRA required discharges: return anticipated and return not anticipated. A Discharge assessment is required with all types of discharges. The manual revealed on Page 2-17 "A Discharge Assessment - return not anticipated (MDS) must be completed not	F 640	3. MDS Coordinator was inserviced by the Administrator on 9/11/19 regarding the requirements for Completion and Transmission of MDS-Discharge Assessment in accordance with federal guidelines. 4. DON/designee will perform a monthly audit of all residents who were discharged to ensure that Discharge Assessment MDS were completed timely. Audit will be done monthly for 6 months or until 100% compliance is reached. Outcome of the audit will reported monthly to the Administrator and quarterly to the QA Committee for further discussion.	

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F 640	Continued From page 3 later than discharge date + 14 days. The assessment must also be transmitted to the QIES ASAP system not later than the MDS completion + 14 days." On 8/22/19 at 10:30 AM, the MDS coordinator confirmed that there was no MDS discharge assessment completed for the resident's discharge date of [redacted] On 8/22/19 at 2:00 PM, the surveyor informed the Administrator and the Director of Nursing of the above concern. They did not provide any further information.	F 640		
F 658 SS=D	NJAC 8:39-11.2 Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to maintain professional standards of clinical practice by not accurately following Physicians orders for the application of a resident's [redacted] for 1 of 38 residents (Resident #5) reviewed for accurately following Physician's orders. The deficient practice was evidenced by the following:	F 658	1. B/L hand splints were immediately removed from Resident #5. No negative outcome was identified after [redacted] were removed. 2. All residents with Physician orders for [redacted] that were written as "donned and doffed" were reviewed and reordered as "[redacted]". 3. All Nursing and Rehab staff will be inserviced by the Staff Development/Nursing Supervisors/Rehab	9/30/19

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F 658	Continued From page 4 On 8/16/19 at 10:58 AM, the surveyor observed Resident #5 dressed well, hair combed and appeared clean. The resident was observed propped in [redacted] wheel chair wearing [redacted] on both [redacted] On 08/22/19 10:16 AM, Resident #5 was observed lying in bed with [redacted]. The surveyor reviewed the records belonging to Resident #5. Resident #5 was admitted to the facility on [redacted] and readmitted on [redacted] with diagnoses that included but were not limited to [redacted]. The surveyor reviewed the resident's physician's order documenting "[redacted] to be donned on from PM to AM care except when an [redacted] is used or an acute medical condition exists at bedtime." On 8/22/19 at 1:07 PM, the surveyor along with the Assistant Director of Nursing (ADON), observed Resident #5 lying in bed, dressed and wearing [redacted]. The Surveyor referred to a picture on the resident's wall of the [redacted] documenting "Donned PM and Doffed AM." The ADON stated, "[redacted] should be removed after AM care" by the Certified Nursing Assistant (CNA). On 8/22/19 at 2:00 PM, the surveyor interviewed the CNA that regularly cares for Resident #5. The CNA explained to the surveyor that she was confused with "the Donned and Doffed" verbiage. The CNA did not understand that Donned meant to put on and Doffed meant to take off.	F 658	Director regarding following Physician orders for Splints and Adaptive Equipments accurately specifically ensuring that all orders are written clearly for all staff to understand. Inservices will be completed on 9/27/19. 4.The Rehab Director will perform a monthly random audit of residents with Physician orders for Splints/Adaptive Devices to ensure that staff are following Physician orders accurately and orders are written for all staff to understand clearly. Random audits will be performed monthly for 6 months or until 100% compliance is reached. Outcome of the audit will be reported to the Administrator and the QA Committee quarterly for further discussion	

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F 658	Continued From page 5 On 8/22/19 at 2:30 PM, the surveyor met with the Administrator and Director of Nursing who explained that using the "Donned and Doffed" words were too clinical and agreed that it could be confusing.	F 658		
F 755 SS=D	NJAC 8:39- 29.2 (d) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		9/30/19

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F 755	Continued From page 6 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure records for a Schedule IV controlled substance medication were accurate. This deficient practice was identified for Resident #102, 1 of 35 residents reviewed for medication accountability as evidenced by the following: On 8/21/19 at 8:59 AM, the surveyor observed the [redacted] medication nurse (MN) prepare medication for administration to Resident #102. The MN removed [redacted]) from the resident's stock bottle, leaving a very small amount in the bottle. The MN hesitated documenting the removal of the [redacted] dose on the Controlled Drug Administration Record Liquids (CDAR) sheet, which keeps a continued accountability record. The MN informed the surveyor that there was a discrepancy between the stock bottle of [redacted] belonging to Resident #102 which only had a small amount of medication left and the amount documented on the CDAR sheet. The CDAR sheet documented [redacted] left in the bottle prior to the [redacted] being removed by the MN for administration to Resident #102. The MN could not explain the reason for the discrepancy. The surveyor reviewed the CDAR sheet for Resident #102's [redacted] with the MN and the Assistant Director of Nursing (ADON). The last entry on the CDAR sheet (dated [redacted] at 1:00 AM) documented [redacted] left	F 755	1. There was no negative outcome for Resident #2. 2. DON/ADONs inspected all medication cart narcotic cabinets in the entire facility and performed a count of all controlled substances, there were no other discrepancies found. 3. All Licensed staff were inserviced by the Staff Development/Nursing Management regarding the requirements of F755 specifically ensuring that controlled substance records are maintained accurately. 4. The Pharmacy Consultant will perform a monthly audit of controlled substances records to ensure that records are maintained accurately. Monthly audit will be performed for 6 months or until 100% compliance is reached. Outcome of the monthly audit will be reported to the Administrator and quarterly to the QA Committee for further discussion.	

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F 755	Continued From page 7 in the resident's stock bottle of [redacted] The surveyor observed a visual review of the actual amount of medication with the MN and the ADON present, which revealed, approximately [redacted] left. The MN and ADON could not explain why there were a discrepancy between the CDAR sheet, and the amount left in the bottle. On 8/21/19 at 10:54 AM, the surveyor observed the MN perform a count of all controlled substances in the medication cart narcotic cabinet. There were no other discrepancies found. On 8/21/19 at 11:09 AM, the surveyor interviewed the Registered Pharmacist (RPh) from the Provider Pharmacy who stated that liquid medications are measured in a graduated cylinder for accuracy before dispensing in a medication bottle. The RPh stated that there should not have been a discrepancy between the CDAR sheet and the actual amount in the bottle. On 8/21/19 at 11:30 AM, the surveyor informed the Director of Nursing (DON) and the Administrator (ADMIN) of the facility of the [redacted] accountability discrepancy. The DON and ADMIN could not provide any further information to explain the discrepancy.	F 755		
F 812 SS=D	NJAC 8:39-29.3(a)(1) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		9/30/19

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F 812	Continued From page 8 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to a.) store potentially hazardous foods in a manner to prevent food borne illness; and, b.) failed to maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development of food borne illness. This deficient practice was evidenced by the following: On 8/15/19 at 10:31 AM, in the presence of the Dietary Director, the surveyor observed the following: 1. In the food preparation area, the surveyor observed a pipe attached to the left side of the oven soiled with a thick, black colored grease-like substance. Above the oven, the surveyor observed one light fixture soiled with a brown colored grease-like substance.	F 812	1. See immediate actions taken below: Pipe attached to the left side of the oven was immediately cleaned. Light fixture was replaced with a new one Spice containers were discarded and replaced with new ones. The standing freezer was immediately put out of service. The fans were immediately put out of service. 2. The Food Service Director and Dietary District Manager performed a sanitary inspection of the kitchen areas and equipment to ensure that the kitchen environment and equipment were cleaned and sanitized as per requirement. No other findings found. 3. The Food Service Director will inservice all Dietary staff on the requirements of F812 in ensuring that potentially hazardous foods are stored in a manner	

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F 812	Continued From page 9 2. In the food preparation area, the surveyor observed two spice container tops soiled with gray colored particulates. 3. The surveyor observed a standing freezer with a one-inch thick ice build-up around the inside perimeter. The surveyor also observed ice buildup on the lid of a one-gallon ice cream container. 4. The surveyor observed a fan in use in the dish washing area, and a fan in use in the back of the kitchen. The surveyor observed that both fans' blades were covered in dust-like particulates. 5. The surveyor observed four shelves in the standing refrigerator # 2 with rusted metal exposed on each end of the shelves. During an interview on 8/15/19 at 11:40 AM, the surveyor brought the above concerns to the attention of the Administrator and Director of Nursing. NJAC 8:39-17.2(g)	F 812	to prevent food borne illness and the kitchen environment and equipment are maintained in a sanitary manner to prevent contamination from foreign substances and potential for the development of food borne illness. Inservices will be completed on 9/27/19. 4. The Dietitian/designee will conduct a weekly inspection of the kitchen environment and equipment to ensure that the kitchen environment and equipment are maintained in a sanitary manner. The weekly audit will be performed for 6 months or until 100% compliance is reached. Outcome of the audit will be reported monthly to the Administrator and Safety Committee and quarterly to the QA Committee for further discussion.	