STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315514	A. BUILDING _____ B. WING _____	C 08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EGG HARBOR CARE CENTER	**6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D 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 #: NJ 00136177, NJ 00133455 CENSUS: 53 SAMPLE SIZE: 5 THE FACILITY IS NOT IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES, BASED ON THIS COMPLAINT VISIT.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		9/15/20

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/04/2020

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F 656	Continued From page 1 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00136177 Based on interview, record review and review of other facility documentation, it was determined that the facility failed to revise a resident's comprehensive care plan to reflect a change in status. This deficient practice was identified for Resident #5, 1 of 5 residents reviewed for plan of care and was evidenced by the following: According to the medical record face sheet, Resident #5 was admitted to the facility with diagnoses that included but were not limited to: [redacted]. On 08/25/2020 at 9:51 AM, the surveyor observed Resident #5 in bed laying on a chucks	F 656	Tag Cited: F-656 ¿483.21(b) (1) □ Comprehensive Care Plans Issue Cited: Developing Comprehensive Care Plans Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Care plan of the resident identifier was reviewed and updated as indicated. 2. The Director of Nursing Services and the Minimum Data Set Coordinator will	

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F 656	Continued From page 2 pad. The resident had a clean appearance and was wearing a hospital gown. There were no odors in the room. The resident stated, "I go to the bathroom on the pad. I do everything in bed. I like to rest here. I'm weak." He/she also stated, "I exercise, but I can't walk." Resident #5 also stated, "The staff is nice, but they don't get to me quickly." On 08/25/2020 at 10:58 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who usually cared for Resident #5. The CNA stated that the resident was complete care and a little depressed because Resident #5 thought he/she was going home. The CNA reported that Resident #5 used to use the toilet, but could not any longer because he/she would fall too much. The resident sometimes asked for the bed pan. The CNA stated that the resident was incontinent. When asked if the resident wore incontinence briefs, the CNA stated "yes" because the resident was a "heavy wetter." The CNA also explained that Resident #5 required a Hoyer Lift and two staff members to transfer from bed to a high-backed wheelchair. The resident could not walk at all and needed staff to push the wheelchair. The CNA stated that Resident #5 got out of bed when he/she felt like it. On 08/25/2020 at at 11:30 AM, the surveyor reviewed the Activities of Daily Living (ADL) care sheets, which were completed by the nursing staff. The sheet for August 2020 revealed that Resident #5 was always incontinent of bladder, when the assessments were recorded. The ADL sheets from May, June and July 2020 indicated that Resident #5 was incontinent of bladder at least 95% of the time.	F 656	meet with the Administrator to review the facility protocols regarding resident assessment including policies and practices to ensure all sections of the resident assessment instrument specified by the State are accurately completed as required. 3. The Administrator will ensure that the facility policy and practices are consistent with the requirements stated in the regulations. 4. The Director of Nursing Services and the MDS Coordinator will meet to review the needs of individuals affected by the deficient practice. The Director of Nursing Services will ensure that the MDS Coordinator obtains and accurately enters for the resident, consistent with the resident□s rights and which includes measurable objective and timeframes to meet the resident□s medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. 5. The Director of Staff Development will meet with the Director of Nursing to develop a training program for facility staff that complete Minimum Data Sets and/or periodically arrange for training. As necessary, the Director of Staff Development will train facility staff about the facility policy and practices to ensure that accurate methods of obtaining and entering accurate information in resident assessments. Training will address the facility policy and practices. This will be documented. Staff members who fail to follow the facility policies and practices will be reprimanded and provided additional	

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F 656	Continued From page 3 The surveyor reviewed the most recent Quarterly Minimum Data Set (MDS), an assessment tool, dated [redacted], which revealed that Resident #5 had [redacted]. The MDS also indicated that the resident was occasionally incontinent of bowel (1 episode of incontinence in the 7 day look-back period) and bladder (less than 7 episodes of incontinence in 7 days). The most recent 5-day MDS, dated [redacted], also revealed that Resident #5 was occasionally [redacted]. The most recent full MDS was an Admission Assessment, dated [redacted]. That MDS indicated that Resident #5 was [redacted]. On 08/25/2020 at 1:34 PM, the surveyor interviewed the MDS Coordinator regarding the incontinence information. He stated that he found the information from the Skilled Nurse's Notes. The MDS Coordinator pointed to a Skilled Nurse's note in the resident's chart, dated 06/01/2020, which revealed that Resident #5 was "occasionally incontinent" of bowel and bladder. On 08/25/2020 at 1:35 PM, the surveyor interviewed the Director of Nursing (DON), who stated that Resident #5 was "incontinent for the majority of the time. Sometimes [he/she] asks for the bedpan or toilet." When asked why the MDS only indicated that Resident #5 was occasionally incontinent, the DON stated that incontinence, "might not have occurred in the look-back period." The surveyor reviewed the resident's current comprehensive care plan, dated 02/03/2020, which did not address incontinence at all. The only reference to toileting appeared on the resident's care plan for "Falls." That intervention,	F 656	training. 6. The facility has determined that all residents have the potential to be affected. 7. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON or Designee will audit 3 resident charts weekly to ensure comprehensive care plans are updated and in place for 6 weeks. Interdisciplinary team will monitor nurse notes and direct report from nursing in morning QA meetings to ensure care plans are put into place for any changes requiring a care plan update. QA committee will review weekly to ensure compliance. Corrective action completion date: September 15, 2020	

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F 656	Continued From page 4	F 656		

with a start date of 06/24/2019, revealed that staff should offer assistance with toileting at night to Resident #5.

During a post survey interview on 08/26/2020 at 1:50 PM, the DON stated to the surveyor that incontinence was not addressed during the resident's initial care conference meeting in June 2019 because Resident #5 was continent at that time.

On 08/26/2020 at 2:45 PM, during a post-survey interview, the DON stated that care plans were updated on readmission, change in status, quarterly or after an incident/accident report. She stated that either the MDS Coordinator or the Unit Manager (UM) were responsible for revising a resident's care plan. The DON stated that the MDS Coordinator was out for 28 days during the pandemic and that the UM was also out on leave. The DON stated, "We were acting on Executive Order that said we didn't have to address the MDS or the care plan. I was working with four nurses."

Review of the facility's "Care Plans-Comprehensive Policy," initiated March 2013, revealed the following:

"Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change.

The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans:

a. When there has been a significant change in the resident's condition;

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F 656	Continued From page 5 b. When the desired outcome is not met; c. When the resident has been readmitted to the facility from a hospital stay; and d. At least quarterly." NJAC 8:39-27.1 (a)	F 656		