STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING _____ B. WING _____	C 10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE	43 N WHITE HORSE PIKE HAMMONTON, NJ 08037

(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 # NJ 129873 CENSUS : 208 SAMPLE SIZE: 3	F 000		
F 658 SS=D	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: COMPLAINT # NJ 129873 Reference : New Jersey Statutes, Annotated Title 45 Chapter 11, Nursing Board. The nurse practice act for the state of New Jersey states; "the practice of nursing as a Registered Professional Nurse is defined as diagnosing, and treating human response to actual or potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: "The practice of nursing as a Licensed Practical Nurse is defined as performing tasks, and responsibilities within the framework of casefinding, reinforcing the patient and family teaching program through health teaching, health	F 658	1. The 7PM-7AM Nursing supervisor was immediately reeducated on the facility policy titled □Charting and Documentation□ which reveals that □All incidents, accidents, or changes in resident□s condition must be recorded□. No residents were negatively affected. Resident #3 no longer resides in the facility. 2. All residents had the potential to be affected. A facility wide audit was conducted on all residents exhibiting behaviors to ensure appropriate documentation occurred. No further issues were identified. 3. All nursing staff was re-educated by the ADON and Facility Educator on the facility policy □Charting and Documentation□ to ensure all incidents, accidents or changes in resident□s	12/9/19

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

Electronically Signed | 12/02/2019

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F 658	Continued From page 1 counseling and provision of supportive and restorative care, under the direction of a Registered Nurse, or otherwise legally authorized physician or dentist." Based on interviews, review of the Medical Records (MR), and other pertinent facility documentation on 10/31/2019, it was determined that the facility staff failed to consistently document in the Progress Notes (PN), implement the Care Plan for documentation of behaviors, as well as follow their own facility policy titled "Charting and Documentation" for 1 of 3 sampled residents (Resident #3). This deficient practice was evidenced by the following: 1. According to the facility "Admission Record," Resident #3 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted]. According to the Minimum Data Set (MDS), an assessment tool dated [redacted] Resident #3 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating that Resident #3 had [redacted] cognition. Review of Resident #3's Care Plan (CP) undated revealed: Resident exhibits behavior symptoms such as verbal requests to go home due to changes in environment. Goals included : The resident's safety will be maintained through the review date with a target date of [redacted]. Interventions included but were not limited to: Document all behaviors, attempt to identify pattern to target interventions, distract resident with activities of interest....	F 658	condition are recorded in the medical record. The Unit Managers will conduct weekly audits x 4 weeks then monthly x 3 months starting on 11/29/19, on charting and documentation to ensure all incidents, accidents or changes in resident□s conditions are recorded in the medical record. 4. The DON/ADON will conduct random weekly audits x 4 weeks and monthly x 3 months starting on 11/29/19, on charting and documentation to ensure compliance. All findings will be brought to the monthly QAPI meeting x 3 months and determine if further action is necessary.	

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F 658	Continued From page 2 Review of an Investigation Form dated [redacted] revealed the following: Resident #3 stated that yesterday (10/26/2019) staff and the police department would not allow Resident #3 to leave the building with Resident #3's [redacted]. Because of that Resident #3 went in to the bathroom in the morning and [redacted] using a [redacted]. The Assistant Director of Nursing (ADON) asked Resident #3 if [redacted] had purposely [redacted] to the [redacted] holder Resident #3 responded yes, for attention. Review of a Progress Note (PN) dated [redacted] 18:14 (6:14 p.m.) revealed : called to speak to resident and Resident #3's [redacted] who called 911 stating Resident #3 is scheduled to go home. Spoke to the Unit Manager who verified resident has no discharge scheduled. Explained to the police the situation and police spoke to manager and [redacted]. Resident advised to continue to stay here. The [redacted] left. Review of a Accident/Incident Report dated [redacted] at 12:15 a.m., revealed: Resident #3 had a unwitnessed fall, resident would benefit from round the clock [redacted] .Resident #3's high [redacted] contributed to the fall. During a post survey telephone interview on 11/6/2019 at 12:45 p.m., the 7 p.m. to 7 a.m. Night Supervisor stated that Resident #3 had taken the dinner tray and threw it on the floor. The Supervisor further stated that after the fall Resident #3 was "yelling." The Supervisor also stated she checked on Resident #3 frequently, hourly, because she did not know what Resident #3 would do next.	F 658		

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F 658	Continued From page 3 The Supervisor further stated that the resident did not realize she had to ask for the [redacted], it did not seem like it was crossing over in the brain. Resident #3 was talking into the call bell to Resident #3's [redacted] I said this (Resident #3) has a lot of behaviors we don't know of. The Supervisor also stated it is not documented anywhere that the resident was checked frequently because she was working on the incident report for the fall. .Review of a facility policy titled "Charting and Documentation" reviewed 5/2017 under "Policy Interpretation and Implementation." 3. revealed : All incidents, accidents, or changes in the resident's condition must be recorded." NJAC 8:39-27:1 (a)	F 658		

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	060113	A. BUILDING: _____ B. WING _____	C 10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION AND H	43 N WHITE HORSE PIKE HAMMONTON, NJ 08037

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H3480	8:43E-10.11(c)(3) Other Rprtng Rqrmnts Unrltd to Pt Sfty Act Examples of reportable events in the nature of physical plant and operational interruptions, include, but are not limited to, the following: Fires, disasters, or accidents that result in injury or death of patients, residents or employees, or in evacuation of patients or residents from all or part of the facility. This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ 129837 CENSUS : 208 SAMPLE SIZE : 3 Based on interviews, review of the Medical Records (MR), and other pertinent facility documentation on 10/31/2019, it was determined that the facility staff failed to immediately notify the New Jersey Department of Health (NJDOH) of a [redacted] in the facility that occurred on [redacted]. The event was reported via Hippocrates on [redacted] at 8:15 p.m. This deficient practice is evidenced by the following. 1. According to the facility "Admission Record," Resident #3 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted] and [redacted]. According to the Minimum Data Set (MDS), an assessment tool dated [redacted] Resident #3	H3480	1. The NJ Department of Health reportable event hotline was notified via telephone by the facility Administrator on [redacted]. The Hippocrates Long Term Care facility reportable event form was faxed to the Department of Health on [redacted]. The Corporate Director of Quality Assurance re-educated the Administrator on reportable events per state guidelines. The Administrator then re-educated all department heads on reporting significant events per state guidelines. Resident #3 no longer resides in the facility. 2. All residents had the potential to be affected however no residents were negatively affected. 3. The Corporate Director of Quality Assurance re-educated the Administrator on reportable events per state guidelines. The Administrator then re-educated all department heads on reporting significant events per state guidelines. The Administrator will conduct weekly audits x	12/9/19

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H3480	Continued From page 1 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating that Resident #3 had [redacted] cognition. Review of Resident #3's Care Plan (CP) undated, revealed: Resident exhibits behavior symptoms such as verbal requests to go home due to changes in environment. Goals included : The resident's safety will be maintained through the review date with a target date of [redacted] Interventions included but were not limited to: Document all behaviors, attempt to identify pattern to target interventions, distract resident with activities of interest.... Review of an Investigation Form dated [redacted], revealed that Resident #3 stated yesterday (10/26/2019) staff and the police department would not allow Resident #3 to leave the building with Resident #3's [redacted]. Because of that, Resident #3 went in to the bathroom in the morning and [redacted] on [redacted] using a [redacted]. The Assistant Director of Nursing (ADON) asked Resident #3 if they had purposely set [redacted] the [redacted], Resident #3 responded "yes, for attention." Review of a Hippocrates Long Term Care Facility Reportable Event Form not dated/ not timed revealed the following: Patient started a [redacted] in their bathroom, [redacted] with fire damage to the bathroom. The Hippocrates Reportable Event form was faxed to the NJDOH on [redacted], [redacted] at 15:35 (3:35 p.m.) by the Administrator. Review of a Facility policy titled "Reporting a [redacted] Alarm" date initiated 2/2018, revealed under "Policy Statement" 7. When the residents are deemed safe and clearance is obtained by local [redacted] officials or announced internally,the facility	H3480	4 weeks and monthly x 3 months starting on 11/29, to ensure all significant events are reported timely per NJ Department of Health Guidelines. 4. The Administrator/DON will review all significant events monthly x 4 months starting on 11/29, to ensure compliance with reporting guidelines. All findings will be brought to the monthly QAPI meeting x 4 months and determine if further action is necessary.	

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H3480	Continued From page 2 administrator/designee will report per guidelines set forth by the Department of Health.	H3480		