STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315268	A. BUILDING _____ B. WING _____	C 08/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKHAVEN HEALTH CARE CENTER	**120 PARK END PLACE EAST ORANGE, NJ 07018**

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F 000	INITIAL COMMENTS COMPLAINT #: NJ00133806; NJ00134092; NJ00136716; NJ00135190 CENSUS: 106 SAMPLE: 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 842 SS=D	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,	F 842		8/31/20

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

Electronically Signed 08/31/2020

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	F 842		

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 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;

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F 842	Continued From page 2 (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 #NJ00133806 Based on observation, interview, and record review, it was determined that the facility failed to ensure that the Dialysis Communication Form (DCF) was maintained in the medical records. This deficient practice was identified for Resident #2, 1 of 1 resident sampled for dialysis and was evidenced by the following: A review of the Admission Summary (Face Sheet) showed that Resident #2 was re-admitted to the facility, [redacted] three times a week every Monday, Wednesday, and Friday. The Face Sheet also disclosed that the resident had diagnoses that included, but were not limited to, [redacted] Further review of Resident #2's medical record revealed that there was no DCF contained in the medical record. On 08/19/2020 at 8:50 AM, Registered Nurse/Unit Manager (RN/UN) stated that the facility utilizes the DCF in a binder as a communication between the [redacted] Center and the facility. The RN/UM further noted that the top portion of the DCF is filled out by the facility	F 842	1) Affecting resident #2, no residents were affected by this deficient practice. 2) All residents on [redacted] treatment have the potential to be affected by this deficient practice. All medical records of [redacted] residents for the past 3 months will be checked/audited to ensure that all [redacted] communication forms are maintained as part of their medical record file. 3) a) Unit Clerks were re-educated that all [redacted] communications sheets should be filed in the resident's medical record. b) Medical Record Personnel was re-serviced in ensuring that medical records of each resident are complete and includes communication forms with other centers including [redacted] communication forms if applicable. c) All [redacted] resident's charts will be color-coded with labels for easy identification by the unit clerks and the medical record personnel. 4) DON/ADON will conduct monthly audits on the completeness of the medical records of [redacted] residents for 3 months then quarterly for 3 quarters.	

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F 842	Continued From page 3 nurse of resident's information, vital signs (v/s), and medications (meds) administered before transfer to [redacted] Center, and signed by a nurse. She indicated that the lower portion of the DCF would be filled out by the [redacted] Center nurse and the endorsement regarding the resident's condition after the [redacted] treatment. On that same date and time, the RN/UM informed the surveyor that she could not remember information about Resident #2. During the interview on 08/19/2020 at 9:14 AM, the RN informed the surveyor that she makes sure that the DCF is filled out correctly to communicate to the [redacted] Center important information like recent hospitalization, new meds, and change in the condition of the resident. She further stated that she reviews the DCF and follows up if there were recommendations when the resident returns from the [redacted] Center. At that time, the RN stated that she was the assigned nurse of Resident #2 and could not remember information about the resident because it was "a while ago." On 08/19/2020, at 10:50 AM, the surveyor called and left a message at the [redacted] Center twice. The [redacted] Center did not return either of the surveyor's calls. On 08/19/2020 at 1:51 PM, the Assistant Director of Nursing (ADON) informed the survey team that the facility utilized an individual binder as communication between the facility and the DC. The ADON explained to the surveyors that the facility's receiving nurse reviewed the	F 842	All findings will be reviewed during the Quarterly QAPI meeting. QAPI committee will Assess if further audits will be warranted.	

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F 842	Continued From page 4 communication binder for any information or recommendation written on that date. The ADON indicated that communication was written on the DCF and should be filed in the resident's medical records. She further stated that the DCF was "probably" left in the [redacted] Center on 01/17/2020, during the last [redacted] treatment. On 08/19/2020 at 2:35 PM, the DON informed the surveyors that the DCF was part of Resident #2's medical records and that it is the communication between the facility and the [redacted] Center for resident's coordination of care. The DON stated that she was unable to locate Resident #2's DCF. A review of the [redacted] Management ([redacted]) Policy, with a reviewed date of 5/2020, provided by the ADON indicated, "Assure facility completed [redacted] communication form accompanies resident to [redacted] on treatment days, to communicate resident information and coordinate care between [redacted] Center and facility," and "[redacted] center personnel to complete [redacted] communication form and return to the facility, upon return from [redacted] Center, review information provided on [redacted] communication form, communicate and address as appropriate, complete post-[redacted] information and place in resident's medical record." NJAC 8:39-27.1(a)	F 842		