STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315174	A. BUILDING _____ B. WING _____	C 10/06/2021

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DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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F 000	INITIAL COMMENTS Complaint#: NJ148957, NJ149122 Census: 203 Sample Size: 3 THE FACILITY IS NOT IN SUBSTANTIAL 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 provide as a result of PASARR	F 656		12/1/21

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

Electronically Signed | 11/04/2021

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F 656	Continued From page 1 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#: NJ148957, NJ149122 Based on observations, interviews, medical record reviews, and review of other pertinent facility documents on 10/6/2021, it was determined that the facility failed to develop and implement a comprehensive care plan for incontinence and discharge for 2 of 3 residents (Resident #1 and Resident #2). The facility also failed to follow its policy titled "Care Plans-Comprehensive." This deficient practice was evidenced by the following: Review of the Electronic Medical Records (EMRs) were as follows: 1. According to the "Admission Record (AR)," Resident #1 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted] due to	F 656	1. Resident #1's care plans were updated to include incontinence care and discharge planning as applicable. Resident #2's care plans were updated to include incontinence care and discharge planning as applicable. 2. All residents have the potential to be affected by the same deficient practice. All incontinent residents identified on the facilities 672 were reviewed for incontinent care plans and updated as identified. All short-term residents were reviewed by social work and discharge care plans were implemented consistent with the resident6s current discharge plane. 3. All licensed nurses and social work were in-serviced by the in-service coordinator on developing comprehensive	

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F 656	Continued From page 2 [redacted] According to the Minimal Data Set and (MDS), an assessment tool dated [redacted], Resident #1 had a Brief Interview of Mental Status (BIMS) score of [redacted] which indicated the resident was [redacted]. The MDS also showed Resident #1 needed extensive assistance with Activities of Daily Living (ADLs) and was incontinent of [redacted] A review of Resident #1's Care Plan (CP) showed no evidence that an incontinence CP was developed for [redacted] incontinence. During an interview on 10/6/2021 at 2:00 p.m., the MDS Coordinator stated that the IDT (Interdisciplinary Team) meets and discusses the CPs needs, and a CP should be in place for anything that triggers on the MDS. She explained that if something is triggered or is a resident's need, it should be on the CP. The MDS Coordinator continued to explain that the Unit Manager was responsible for developing the CP and confirmed there was no incontinent CP for Resident #1. During an interview on 10/6/2021 at 2:26 p.m., the Unit Manager/Licensed Practical Nurse (UM/LPN) stated the Unit Managers develop the resident's CP. The UM/LPN explained that the CP's purpose is to give a broad picture of the resident and how to care for them. The LPN/UM also stated there should be an incontinent CP for Resident #1, but there is not one. When asked	F 656	care plan upon admission. The in-service included the necessity for timely implementation of comprehensive care plans on admission including but not limited to discharge and incontinence. A new admission checklist was implemented by the DON for the IDT to review the morning after admission. Essential admission care plans will be reviewed in morning meeting. 4. The DON/ designee will audit a sample of new admission for necessary implementation of care plans. Negative findings will have immediate corrective action. The audits will occur weekly x 4 weeks and then monthly until compliance is met.	

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F 656	Continued From page 3 by the Surveyor why she did not develop an incontinence CP for Resident #1, she did not respond. 2. According to the facility AR, Resident #2 was admitted to the facility on [redacted] and readmitted on [redacted] with diagnoses which included but were not limited to: [redacted] A review of the MDS, dated [redacted] showed Resident #2 had a BIMS score of [redacted], indicating the resident was [redacted]. The MDS also showed that Resident #2 needed extensive assistance with transfers and hygiene, had limited bed mobility, and needed assistance with dressing. A review of Resident #2's Progress Notes (PNs) dated [redacted] revealed Resident #2 goal for discharge was to return to the community. A review of Resident #2's MR revealed no CP for discharge planning. During an interview on 10/6/2021 at 1:39 p.m., the Assistant Director of Nursing (ADON) stated the Social Worker (SW) was responsible for the discharge CP. The ADON also stated the discharge care planning begins upon admission. During an interview on 10/6/2021 at 2:00 p.m., the SW stated she was responsible for developing and implementing the discharge care plan. When asked by the Surveyor why she did not initiate a discharge CP for Resident #2, the SW stated, "I don't know why it wasn't done." She also stated the discharge process started on	F 656		

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F 656	Continued From page 4 admission, and she should have followed the facility's care plan policy. Review of the facility policy titled "Care Plans-Comprehensive," revised date October 2019 revealed the following: Under: Policy: "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident." Under: Procedure: "The comprehensive, person-centered care plan will ...Include the resident's stated goals upon admission and desired outcomes; Include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire; ... #2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. #8. The comprehensive person-centered care plan will: a. Include measurable objectives and timeframes. b. described as services that are to be furnished to attain or maintain a residence size, practical, physical, mental, and psychosocial well-being. d. Include the resident stated goals upon admission and desired outcomes. e. Include the resident stated preferences and potential for future discharge, including his or her desire to return to the community, and any referrals made to local agencies or entities to support such a desire...." N.J.A.C.: 8:39-27.1(a)	F 656		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d)	F 745		12/1/21

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F 745	Continued From page 5 §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Complaint#: NJ149122 Based on interviews, medical record reviews, and review of other pertinent facility documents on 10/6/2021, it was determined that the facility's Social Worker (SW) failed to provide social services needs for a resident and assist a resident in obtaining needed services from outside entities, as required by the "Job Description for Social Worker." The SW also failed to follow the facility's "Discharge-Summary" policy for 1 of 3 residents (Resident #2). This deficient practice was evidenced by the following: Review of the Electronic Medical Records (EMRs) is as follows: According to the facility's Admission Record (AR), Resident #2 was admitted on [redacted] and readmitted on [redacted] with diagnoses which included but were not limited to: [redacted] A review of the Minimum Data Set (MDS), an assessment tool dated [redacted], showed Resident #2 had a Brief Interview of Mental Status (BIMS) score of [redacted] indicating the resident was [redacted]. The MDS also showed that Resident #2 needed extensive assistance with transfers and hygiene, bed mobility, and dressing assistance.	F 745	1. Resident #2's care plans were updated to include discharge planning 2. All residents have the potential to be affected by the same deficient practice. Social Work reviewed all short-term residents discharge plans with the resident and/or designated representative. SW reviewed and updated, if applicable, current discharge planning for residents and discussed with IDT. SW and the IDT team to discuss all upcoming discharges to ensure appropriate discharge location and the necessary adaptive equipment. 3. Clinical staff was in-serviced by the staff educator on the discharge process by the in-service coordinator specifically focusing on initiating timely discharge planning, discharge locations accepting of residents6 adaptive devices, and appropriate referrals. Timely documentation of discharges will be covered as well as completion of the discharge checklist by SW. 4. The Administrator/Designee will audit a sample of short-term residents for discharge planning. Negative findings will be addressed immediately. The results of these audits will be discussed at QAPI.	

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A review of the Progress Notes (PN) revealed an "Admission Note" dated [redacted] at 5:21 p.m., written by the Assistant Director of Nursing (ADON), which showed Resident #2 had a discharge goal to return to the community.

A review of Resident #2's Care Plan (CP) revealed no CP for discharge planning.

Review of a "Notice of Transfer/Discharge" form dated [redacted] revealed Resident #2's signature to confirm the discharge to a [redacted].

Review of a "Team: IDT Discharge Instructions" with an effective date of [redacted] written by the UM/LPN revealed Resident #2 had a discharge date of [redacted]. The discharge instructions showed that Resident #2 needed a commode.

Review of the "Order Recap Report (ORR)" dated [redacted] revealed a Physician's Order (PO) to discharge Resident #2 dated [redacted]

A review of a second PN, under "General Documentation," dated [redacted] at 11:51 a.m., written by the Licensed Practical Nurse (LPN), revealed that Resident #2 was discharged at 11:45 a.m. According to the PN, discharge instructions were reviewed and provided to the resident. However, further review of the MR showed Resident #2 returned to the facility on [redacted] and was readmitted.

The MR revealed a second PO dated [redacted] to discharge Resident #2.

A review of the PN eMAR -(Electronic) Medication

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F 745	Continued From page 7 Administration Note dated [redacted] at 10:48 a.m, written by LPN #1, revealed Resident #2 received morning medications. During a telephone interview on 10/6/2021 at 1:11 p.m., the LPN assigned to Resident #2 stated she discharged Resident #2 on [redacted] with instructions that the resident verbally understood. According to the LPN, Resident #2 returned to the facility later that same day because the location he/she was transported to would not accept the wheelchair. A review of Resident #2's MR revealed that the resident did not have a "Discharge Planning Checklist (DCPC)," required as per the facility's SW job description. The Surveyor requested a blank DCPC form which revealed discharge steps to follow when a resident leaves the facility to be discharged, which included: " ...Discharge Care Plan Meeting scheduled with IDCP (Interdisciplinary Care Plan) Team, family and/or resident representative, SW Documentation describes details of discharge plan prior to discharge ... Update Discharge Care Plan to reflect details of plan, DME (durable medical equipment) ordered and obtained ...Discharge Instructions completed and signed by all disciplines, including physician ...Discharge instructions faxed/sent to PCP (Primary Care Physician) and documented, Discharge instructions provided to the resident and/or resident representative ...Discharge note, 3-day post-discharge follow up note documented in EHR (electronic health record) ... Post-discharge follow-up calls completed on log." During an interview on 10/6/2021 at 10:30 a.m., the Surveyor asked the SW who was responsible for completing the discharge summary; the SW	F 745		

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stated there was no discharge summary documentation for Resident #2's discharge back to the community on [redacted] because she was too busy and did not document it in the system yet. The SW explained that the discharge summary should be written by herself the day the (patient) resident is leaving. The SW also stated on [redacted] she called the Gloucester County Board of Social Services (SS) about Resident #2 several times and left messages, but she never spoke to anyone.
The SW further stated that Resident #2 was discharged back to the community to a motel on [redacted]. According to the SW, on [redacted], she called an outside entity, Gloucester County Board of Social Services (SS), for Resident #2, so if the resident wasn't happy with the motel, the resident could go there for emergency housing. The SW stated she never spoke to a person at the County's Board of SS, only left a message.

During a second interview at 2:00 p.m., when the Surveyor asked the SW if Resident #2 had a commode, according to the resident's IDT (Interdisciplinary Team) discharged instructions, the SW stated she would check with nursing to see if the resident needed the commode. She further stated that if Resident #2 needed the commode, it depended on the size and height of the toilets, and the resident would make do. The SW also stated Resident #2 did not receive the raised toilet seat because the resident did not know if he/she would need it. When asked by the Surveyor if she followed up with Resident #2, she stated that she did not speak with the resident, and she told Resident #2 to call her. The Surveyor asked the SW why Resident #2's DCPC was not completed, she stated the checklist was used to follow discharge planning, but she did not use the checklist, even though it was listed in her

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job description, because she has been doing d/c planning for years. The SW further stated the checklist was a list: for arranging the d/c, talking to the resident or representative, talking to the doctor (physician), d/c planning, and equipment needs. The SW also explained that she was responsible for the discharge plan and goals; she did not know why she did not do them for Resident #2.

During a telephone interview on 10/6/2021 at 3:33 p.m., the Gloucester County Board of SS stated they did not talk to anyone at the facility about Resident #2. The Board stated Resident #2 was screened for placement, then if funded and qualified, he/she would receive emergency assistance, and the resident was transferred to a shelter. The Board also stated Resident #2 was left at the door of the building and was let in by the SS staff.

Review of the "Job Description Social Worker" revealed the following: Under:

"Purpose are the main advocate for residents in the facility ...remain in compliance with DOH (Department of Health) regulations ...." Under: Nature and Scope: " ...Plan and execute safe discharges using Discharge Planning Checklist ..."

Review of the facility policy titled "Discharge-Summary," revised date August 2019 indicated the following: Under: Policy: revealed "When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment." Under: Procedure: revealed "...4. Every resident will be

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F 745	Continued From page 10 evaluated for his or her discharge needs and will have an individualized post-discharge plan. 5. The post-discharge plan will be developed by the Care Planning/Interdisciplinary Team with the assistance of the resident and his or her family and will include: a. Where the individual plans to reside; b. Arrangements that have been made for follow-up care and services, c. A description of the resident's stated discharge goals ...e. How the IDT (Interdisciplinary Team) will support the resident or representative in the transition to post-discharge care...7. The resident/representative will be involved in the post-discharge planning process and informed of the final post-discharge plan ...11. The resident or representative (sponsor) should provide the facility with a minimum of a seventy-two (72) hour notice of discharge to assure that an adequate discharge evaluation and post-discharge plan can be developed. 12. A member of the IDT will review the final post-discharge plan with the resident and family at least twenty-four (24) hours before the discharge is to take place ...13. A copy of the following will be provided to the resident and receiving facility and a copy will be filed in the resident's medical records: a. An evaluation of the resident's discharge needs; b. The post-discharge plan; and c. The discharge summary."	F 745		
F 842 SS=D	N.J.A.C. 8.39-39.4 (f) 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	F 842		12/1/21

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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 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

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F 842	Continued From page 12 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#: NJ148957, NJ149122 Based on interviews, Medical Record (MR) review, and review of pertinent facility documents on 10/6/2021, it was determined that the facility failed to document physician's orders for medications and treatments for 1 of 3 residents reviewed for documentation (Resident #1). This deficient practice was evidenced by the following: A review of the Electronic Medical Records (EMRs) was as follows: According to the "Admission Record (AR)," Resident #1 was admitted to the facility on [redacted] with diagnoses which included but were not limited to: [redacted]	F 842	1. Resident #1 received their medication as per statement by RN#2. 2. All residents have the potential to be affected by the same deficient practice. The missed medication report was run for the month. MD notification was given for missed medication doses. No negative effect noted for any identified resident. Medication errors were completed and issued to the identified nurses. 3. RN #2 was counseled on keeping accurate medical records specifically focusing on signing for the administration of medications and treatments. The policy on medication administration was reviewed by administration and	

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	315174	A. BUILDING _____ B. WING _____	C 10/06/2021

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F 842	Continued From page 13 [redacted] According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted] indicating the resident had [redacted]. The MDS also showed that Resident #1 needed assistance with Activities of Daily Living (ADLs). A review of Resident #1's Care Plan (CP) revealed the following: Under "Focus": Resident may have alteration in comfort R/T (Related To) [redacted], dated [redacted]. Under "Goals": Resident pain goal is to have a [redacted] from [redacted] during movement through the next review date, dated [redacted] under "Interventions": Monitor for S/S (Signs and Symptoms) [redacted] with each interaction. If the resident appears to be [redacted] utilize appropriate non-pharmacological and pharmacological interventions, dated [redacted] Under "Focus": Resident is at risk for [redacted], dated [redacted]. Under "Goals": Resident will be free of episodes of [redacted] through the next review period, dated [redacted]. Under "Interventions": Administer meds (medications) per MD orders, dated [redacted]. Monitor [redacted] per MD orders, dated [redacted]. A review of Resident #1's Physician's Orders (PO's)dated [redacted] revealed the following: [redacted], call MD (Medical doctor) for [redacted] before [redacted] dated [redacted].	F 842	considered to be in compliance with state and federal guidelines. The staff educator educated all licensed nurses about complete and accurate documentation of physicians6 orders for medications and treatments specifically focusing on documenting administration. 4. The ADON/designee will audit the missed medication report weekly x 4 weeks and monthly until compliance is met. The results of these audits will be discussed at QAPI.	

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F 842	Continued From page 14	F 842		

[redacted] evaluation Q (Every) shift, every shift for [redacted] evaluation record [redacted], dated [redacted].

[redacted] Tablet [redacted] mg (milligrams) give 1 tablet by mouth one time a day, dated [redacted].

A review of Resident #1's Medication Administration Record (MAR) dated [redacted] showed no documentation to indicate the above medications and treatments were administered according to the PO's as follows:

[redacted] before [redacted] on [redacted] at 7:30 AM.

[redacted] evaluation Q (Every) shift, every shift for [redacted] evaluation record [redacted] on [redacted] at 3:00 PM.

Glipizide Tablet 5 mg (milligrams), give 1 tablet by mouth one time a day on 9/2/2021 at 9:00 AM.

During an interview on 10/6/2021 at 1:45 PM., Registered Nurse (RN) #1 explained that the nurse should look at the MAR/TAR (Treatment Administration Record), pull the medications from the medication cart, verify the medication or treatment with the PO's, and then dispense the medication. RN #1 further explained that after administering the medication, it is documented on the MAR/TAR with initials indicating the medication or treatment was done. A blank on the MAR/TAR doesn't necessarily mean the medication or treatment was not done but does indicate it was not documented. The RN further stated, "I would expect to see a note in the chart if

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there was a blank in the MAR/TAR." However, a review of Resident #1's Progress Notes showed no evidence that the medication or treatment was administered.

During a telephone interview on 10/6/2021 at 2:24 PM, RN #2 stated that she usually signed out the medications after administering the medications. RN #2 indicated she did administer the medications but must not have signed it out.

A review of the facilities policy titled "Charting and Documentation" dated and revised 1/2020, indicated the following: Under "Policy": All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. Under "Procedure": #1. All observation, medications administered, services performed, etc. must be documented in the resident's medical records. Facility utilizes an EHR (Electronic Health Record) for clinical documentation .... #2 Entries may only be recorded in the resident's clinical record by licensed personnel (e.g., RN, LPN, LVN (Licensed Practical Nurse, Licensed Vocational Nurse) physicians, therapists, etc.) in accordance with state law and facility policy. #6. Documentation of procedures and treatments shall include care-specific details and shall include at a minimum: a. The date and time the procedure/treatment was provided. b. The name and title of the individual(s) who provided care. g. the signature and title of the individual documenting.

N.J.A.C. 8:39-35.2(d)(g)