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 12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	**1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096**

(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 121246, NJ 119747, NJ 128263, NJ 129729, NJ 114460, NJ 122620 CENSUS: 230 SAMPLE SIZE: 8	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		1/1/20

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

Electronically Signed | 12/30/2019

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F 609	Continued From page 1 This REQUIREMENT is not met as evidenced by: COMPLAINT #: NJ 121246, NJ 119747, NJ 128263, NJ 129729, NJ 29724, NJ 114460, NJ 122620 Based on interview, medical record (MR) review, and review of other facility documentation, it was determined that facility failed to notify the New Jersey Department of Health (NJDOH) of injuries of unknown origin for 1 of 8 residents (Sampled Resident #2). This deficient practice was evidenced by the following: 1. According to the Admission Record (AR) Resident #2 was admitted to the facility on [redacted] with diagnoses which included but were not limited to; [redacted] A Minimum Data Set (MDS), an assessment tool, dated [redacted], revealed that Resident #2 had a "Brief Interview for Mental Status" (BIMS) score of [redacted]. Review of Resident #2's Care Plan (CP) revealed the following "Focus", initiated 12/2/19; "[Resident #2] Requires assist[ance] with Activities of daily living R/T [related to] [redacted] ...Interventions/ Tasks..Personal Hygiene...Totally Dependent, X1 (one person assistance)...Transfers...Extensive Assistance X2 (two person assistance)...Bed mobility...Extensive assist X2..." Review of Resident #2's CP revealed the following "Focus" initiated 12/02/19; "[Resident #2] is at risk for falls r/t confusion, gait/ [or]	F 609	1. Resident #2 continues to reside in this facility. Resident #2 had [redacted] record reviewed. No other injuries of unknown origin were sustained by resident #2. The center will notify the New Jersey Department of Health and New Jersey Ombudsman Office of any future injuries of unknown origin related to resident #2. 2. All residents have the potential to be affected by this matter. A review and clarification of CMS guidelines for 483.12 preventing abuse, neglect, mistreatment, and misappropriation was conducted. The facility has completed an audit of all Accidents and Incidents associated of injuries of unknown source. The identified accidents and incidents were reviewed and the facility ensured that abuse was ruled out. The Center will ensure the New Jersey Department of Health and New Jersey Ombudsman Office will be notified of all future center investigations of resident injuries of unknown origins. 3. A review of the facilities policy on Abuse and Neglect was completed by administration and the facility policy is compliant with current CMS and state guidelines on reporting abuse, neglect, mistreatment, and misappropriation. An in-service was developed based on reporting guidelines specifically focusing on injuries of unknown source and the reporting requirement of reporting to the DOH, ombudsman, and one local authority as per the elder justice act.	

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F 609	Continued From page 2 balance problems...Interventions... anticipate and meet resident needs... Educate the resident... about safety reminders..." According to a facility investigation, dated [redacted], Resident #2 sustained a [redacted]. Resident #2 was unable to provide statement due to [redacted]. A facility "Summary of Investigation," signed by the Director of Nursing (DON) dated 12/25/2018, revealed the following; "On 12/25/18 at approximately 8 a.m., an abrasion was noted on [Resident #2's] [redacted] as well as a [redacted] The DON, Administrator, and the MD [Medical Doctor] were immediately notified and an investigation was initiated ...[Resident #2] is [redacted] ...On 12/24[/18] at approximately 20:30 [8:30] p.m., the nursing assistant assisted [Resident #2] to bed. At that time the nursing assistant indicated that [Resident #2's] [redacted]. According to the nursing assistant, [Resident #2] remained in bed the rest of her shift sleeping. The nursing assistant that followed on [the] 11-7 shift indicated that [Resident #2] slept through the night... At 5 a.m., the nursing assistant ...entered the room to change [Resident #2] ... At that time she had her face pressed to the left siderail. They repositioned [Resident #2] and changed her. At that time, they did not notice anything different about her face. At 8 a.m. on 12/25 [/18] the day shift aide [Nursing Assistant] went into [Resident #2]'s room and notified the nurse of the [redacted] ...In conclusion, there is no evidence to substantiate	F 609	Nursing administration, nursing supervision, and all direct care employees were educated on the reporting threshold and requirements for injuries of unknown source. The Administrator will be responsible to ensure the center staff report all accidents/incidents in which a residents sustains and injury of unknown origin to the New Jersey Department of Health and New Jersey Ombudsman Office as per policy requirements. 4. Monitoring of all incident and accidents related to injuries of unknown origin will be reviewed by the facility Nursing Management Team as well as the Regional Nursing Team to ensure timely notification to the DOH and Ombudsman□s Office as well as proper investigation to rule out abuse. A monthly report will be generated and reported at our monthly QA meeting for the next 3 months. The QA committee will review the report and ensure compliance.	

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F 609	Continued From page 3	F 609		

an allegation of abuse. In my professional opinion, it appears her face made contact with the side rail while sleeping in bed..."

Additionally, another investigation related to an injury of unknown origin, dated [redacted], included the following; Resident #2 sustained an injury to [redacted]. According to the facility document titled "Summary of Investigation", written by the DON, indicated the following; "On 2/19/19 at approximately 19:30 [7:30] p.m. an area was noted on [Resident #2's] [redacted]. The DON and MD were notified. An investigation was immediately initiated...While conducting my investigation, I assessed the area. [redacted] [Resident #2] does not appear [to be] in any discomfort...She is restless in bed moving frequently [,] rubbing her skin specifically shoulders against the sheets and up against the padded side rails...In conclusion, the area noted appears to be r/t friction against the padded side rails and/or sheets... There is no evidence to substantiate abuse."

During an interview with the surveyor at 11:03 a.m. on 12/12/19 the DON explained that she did not report these incidents to the NJDOH because abuse had been ruled out. The DON acknowledged that both incidents were injuries of unknown origin. DON stated that Resident #2's injuries of unknown origin should have been reported while the investigation was underway.

Review of a facility policy titled "Abuse", initiated 2/2019, revealed the following; " Policy:...The facility has designated and implemented processes, which strive to ensure the prevention

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F 609	Continued From page 4 and reporting of suspected or alleged resident/ [or] patient abuse, neglect, mistreatment, and/or misappropriation of property... Reporting...Notify the shift supervisor/ charge nurse/ manager immediately if suspected abuse, neglect, mistreatment or misappropriation of property occurs...Notify the local law enforcement and appropriate State Agency (s) immediately (no later than 2 hours after allegation) by agency's designated process after identification of alleged /suspected incident. Initiate Process according to the Elder Justice Act and State specific regulations...Report results of investigation the proper authorities as required by state law..." N.J.A.C. 8:39- 9.4 (f)	F 609		