

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2021
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315257 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 02/11/2021 |
|---|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER CEDAR GROVE RESPIRATORY AND NURSING CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1420 SOUTH BLACK HORSE PIKE WILLIAMSTOWN, NJ 08094 | | |
| (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 142902 CENSUS: 151 SAMPLE SIZE: 6 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 657 SS=D | Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary | F 657 | | 3/11/21 | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/01/2021

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 657 | <p>Continued From page 1</p> <p>team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>C: # NJ142902</p> <p>Based on interviews, Medical Record review, and review of other pertinent facility documentation on 2/11/2021, it was determined that the facility failed to update and implement a care plan timely for contact isolation for 1 of 6 sampled residents (Resident #6). The facility also failed to follow its policy titled "Care Plans, Comprehensive Person-Centered." This deficient practice was evidenced by the following:</p> <p>A review of the Medical Record (MR) revealed the following:</p> <p>1. According to the facility Admission Record (AR), Resident #6 was admitted on [REDACTED] with diagnoses which included but were not limited to, [REDACTED].</p> <p>According to the Minimum Data Set (MDS), an assessment tool dated [REDACTED] Resident #6 had a Brief Interview of Mental Status (BIMS) score of [REDACTED], which indicated the resident was [REDACTED]. The MDS also indicated that Resident #6 needed extensive assistance with Activities of Daily Living (ADLs).</p> <p>A review of Physician/Practitioner Progress Notes (PPPN) dated [REDACTED] indicated that Resident #6 was sent out to the hospital on [REDACTED], diagnosed with [REDACTED] at the hospital, and</p> | F 657 | <p>1) Resident #6 Care plan was immediately implemented and updated for contact isolation</p> <p>2) All residents who have an order for contact isolation has the potential to be affected by the deficient practice.</p> <p>The care plan of all residents with an order for contact isolation have been reviewed to ensure they have been updated. No further deficient practice identified.</p> <p>3)Licensed nurses will be re-educated on the facility policy titled Care Plans, Comprehensive Person-Centered.</p> <p>In clinical meeting, any new residents who are ordered for contact isolation will be reviewed to ensure they were implemented and/or updated.</p> <p>4)10% of residents who are on contact isolation will be audited to ensure the care plans were implemented and/or updated timely weekly x 4, monthly x 3. Results of audits will be presented in monthly QAPI meeting to ensure compliance and reassessed for further action.</p> | | |

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| F 657 | <p>Continued From page 2 returned to the facility on [REDACTED].</p> <p>A review of the "Order Summary Report" dated [REDACTED] revealed an order for contact isolation due to [REDACTED].</p> <p>A review of the laboratory form with a Collection Date of [REDACTED], and a "Report Date of [REDACTED]" for Resident #6 revealed a positive lab result for [REDACTED].</p> <p>A review of Resident #6's Care Plan (CP) dated [REDACTED] showed the following:</p> <p>Under: Focus: Resident #6 "I [REDACTED] [REDACTED]."</p> <p>Under: Goal showed, "I will be free from complications related to infection through the review date."</p> <p>Under: "Interventions" included: "Maintain contact precautions when providing resident care. Provide independent or 1:1 activities as tolerated by the resident. Reduce exposure to other residents while the infection is active."</p> <p>During an interview on 2/11/2021 at 12:55 p.m., the Unit Manager (UM) indicated she was responsible for developing, implementing, and updating a resident's CP. The UM explained, when a resident has been tested positive for an infectious disease such as [REDACTED], the resident's CP should be updated for contact precautions.</p> <p>During a second interview on 2/11/2021 at 4:05 p.m., the UM stated that when Resident #6 was tested positive for [REDACTED], the resident's CP should have been updated within 48 hours.</p> | F 657 | | | |

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| F 657 | Continued From page 3 A review of facility policy titled "Care Plans, Comprehensive Person-Centered" dated 2001 with a revised/reviewed date 3/2020, revealed the following: Under "Policy Statement" "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 "Policy Interpretation and Implementation" revealed "13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. 14. The Interdisciplinary Team must review and update the care plan: ...c. When the resident has been readmitted to the facility from a hospital stay; ..." NJAC: 8.39-27.1 (a) | F 657 | | | |