STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 Standard Survey: 2/6/2020 Census: 106 Sample Size: 24 A Recertification Survey was Conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that a significant change assessment was completed for Resident #20 and #46. This deficient practice was identified for 2 of 24 residents reviewed, and was evidenced by the following: 1. On 1/28/2020 at 9:44 AM, during the initial tour,	F 637	F637 Comprehensive Assessment after a Significant change 1) Residents #20 and #46 were re-assessed for a significant change assessment and completed as necessary 2) A comprehensive review of all Residents MDSs was completed to ensure that no significant change MDSs were missed.	4/1/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 03/03/2020

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 637	Continued From page 1 the surveyor observed Resident #20 lying in bed with eyes closed. A review of the resident's Face Sheet (FS), a one-page admission summary with important resident information, disclosed that the resident had diagnoses which included, but were not limited to, [redacted] A review of the Comprehensive Minimum Data Set (CMDS) dated [redacted] an assessment tool used to facilitate the management of care, indicated a Brief Interview for Mental Status (BIMS) score [redacted] which reflected that the resident's cognition was [redacted] impaired. The CMDS showed that the resident required limited assistance with toileting and independent with bed mobility, transfer, and ambulation. In addition, the CMDS indicated that the resident's weight was [redacted] A review of the [redacted] Quarterly MDS (QMDS), showed a BIMS of [redacted], which indicated that the resident's cognition was severely impaired. The QMDS showed that the resident was noted with a significant decline in activities of daily living (ADLs) requiring total assistance with toileting, extensive assistance with bed mobility, and limited assistance with transfer and ambulation. The QMDS indicated that the resident's weight was [redacted], which means that the resident had a significant weight loss of more than 10% within the last six months. Further review of the MDS revealed that there were no Significant Change MDS's completed when the resident was noted with a significant decline in ADLs and significant weight loss of	F 637	If any resident was noted to have missed a significant change MDS, that MDS will be completed. 3)The Interdisciplinary Care Team was re-educated by the DON on the RAI manual definition of significant changes and the necessity of identifying residents with Significant changes during the care plan conference. A random sample of 10 resident MDSs will be audited monthly by the DON or her designee or to ensure that significant change MDSs were completed as appropriate. 4) Results of the audits will be submitted to QAPI quarterly.	

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F 637	Continued From page 2 14% comparing the CMDS dated [redacted] and the QMDS dated [redacted] On 2/3/2020 at 9:06 AM, the Certified Nursing Assistant #1 (CNA#1) informed the surveyor that Resident #20 was [redacted] impaired and required extensive assistance with ADLs. She stated that the resident experienced a decline in ADLs after hospitalization and fall incident. She further noted that the resident experienced weight loss a few months ago. On 2/4/2020 at 10:11 AM, the survey team met with the Administrator, Director of Nursing, Regional Nurse, and the Registered Nurse/Chief Operating Officer (RN/COO). The DON stated that the QMDS dated [redacted] should have been designated as a Significant Change because of a decline in both ADLs and weight loss to reflect the current condition for Resident #20. 2. On 1/28/2020 at 9:56 AM, the surveyor observed Resident #46 in the lounge area seated in a wheelchair during an activity. On 2/3/2020 at 8:59 AM, the CNA#2 informed the surveyor that the resident was [redacted] impaired and required total assistance with ADLs. She stated that Resident #46 was previously on [redacted] care. CNA#2 could not remember the date when the resident was discharged from [redacted] and said, "it was a few months ago." A review of the resident's FS disclosed that the resident had diagnoses which included but were not limited to [redacted]. A review of the [redacted] and [redacted] QMDS	F 637		

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F 637	Continued From page 3 indicated a BIMS score of , which indicated that the resident was unable to complete the interview, and the resident's cognition was impaired. The and QMDS showed that the resident was on . A review of the Physician Orders dated revealed an order for discharge effective . On 2/3/2020 at 1:21 PM, the DON stated that there should have been a Significant Change Assessment MDS created when the resident was discharged from care. On 2/4/2020 at 10:11 AM, the survey team met with the Administrator, DON, Regional Nurse, and RN/COO and discussed the above observations and concerns. The DON stated the QMDS dated , should have been a Significant Change when the resident was discharged from She further explained that it was an oversight on the part of the facility, not creating a Significant change. On 2/5/2020 at 9:40 AM, the survey team met with the RN/COO who stated, that the facility does not have a separate policy with regards to Significant Change Assessment and that "we follow the RAI (Resident Assessment Instrument) Manual." Refer to F657 and F842 A review of the CMS's RAI Version 3.0 Manual updated October 2019, showed that a Significant Change in Status MDS is required when a resident receiving services discontinues those services; or, a resident experiences a consistent pattern of changes, with either two or	F 637		

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F 637	Continued From page 4 more areas of decline or two or more areas of improvement, from baseline as indicated by comparison of the resident's current status to the most recent CMS-required MDS and should be done within 14 days when determined that there has been a significant change. NJAC 8:39-11.1	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to accurately assess a resident's status in the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care. This deficient practice was identified for 2 of 24 residents, Resident #34 and #69 reviewed. This deficient practice was evidenced by: 1. On 1/28/20 at 10:15 AM, the surveyor observed Resident #34 inside the room, lying in bed and watching TV. The surveyor interviewed Resident #34, who was alert and oriented. The surveyor reviewed Resident #34's FS, which revealed that the resident was admitted on [redacted] with diagnosis that included [redacted]. A review of the resident's MDS, an assessment	F 641	F641 □ Accuracy of Assessments 1) An MDS modification was completed on Resident #34 and #69. 2) A comprehensive review of all resident MDSs was completed to ensure that all diagnosis were active diagnosis and that all wound documentation was accurate. MDS Modifications were made to the MDS as necessary. 3)The Interdisciplinary Care Team Members were re-educated by the DON on accuracy of assessments. A random sample of 10 resident MDSs will be reviewed monthly by the DON or her designee for accuracy of assessments. 4) Results of the audits will be submitted to QAPI Committee quarterly.	4/1/20

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F 641	Continued From page 5 tool used to facilitate the management of care, [redacted] dated [redacted], which reflected that Resident #34 was admitted with a diagnosis of [redacted] and [redacted] On 2/5/20 at 1:30 PM, the surveyor interviewed the DON, who was also responsible for completing the MDS assessment. The DON stated that the resident had a history of [redacted] from prior readmission and confirmed that the MDS was coded inaccurately as it was not an active (current) diagnosis. 2. On 1/28/2020 at 9:31 AM, the Registered Nurse/Supervisor (RN/S) informed the surveyor that Resident #69 was on [redacted] and had a stage four facility acquired [redacted]. A review of the resident's Face Sheet (FS), an admission summary of important resident information, disclosed that the resident had diagnoses which included but were not limited to [redacted] A review of the [redacted] and [redacted] Quarterly MDS (QMDS), reflected a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated that the resident's cognition was [redacted] impaired. The QMDS showed that the resident had [redacted] that was present on admission, which would indicate it was not facility acquired. A review of the person-centered care plan demonstrated that it was reviewed by the facility on [redacted] and [redacted], revealing that interventions were in place for an actual [redacted]	F 641		

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	315304	A. BUILDING ______ B. WING ______	02/06/2020

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F 641	Continued From page 6	F 641		

on the that first began on while the resident was already at the facility.

On 1/31/2020 at 2:00 PM, the survey team met with the Administrator, Director of Nursing, Regional Nurse, and Registered Nurse/Chief Operating Officer (RN/COO) to discuss the above concerns. The DON informed the surveyors that the in the was a facility acquired .

On 2/4/2020 at 9:42 AM, the DON informed the surveyor that the in the started as that progressed to . The DON stated that the resident's was unavoidable and had preventative treatment in place before it became a .

On that same date at 10:11 AM, the DON stated to the survey team that "the MDS was coded incorrectly and should have been coded as facility acquired

On 2/5/2020 at 9:40 AM, the RN/COO in the presence of the survey team stated that there was no separate policy with regards to Resident's Assessment and that "we follow the Resident Assessment Instrument (RAI) Manual."

A review of the CMS's RAI Version 3.0 Manual updated October 2019 titled, "Overview" documented under Page 1-5 "Clinical competence, observational, interviewing and critical thinking skills and assessment expertise from all disciplines are required to develop individualized care plans."

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F 641	Continued From page 7 NJAC 8:39-11.2(e)1; 27.1(a)	F 641		
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 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to revise a comprehensive care plan for 3 of 24 residents, Resident # 20, # 72 and # 34.	F 657	F657 Care Plan timing and Revision 1) Care plans for residents #20, #72 and #34 were reviewed and updated as appropriate.	4/1/20

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F 657 Continued From page 8

This deficient practice was identified by the following:

1. On 1/28/2020 at 9:44 AM, during the initial tour, the surveyor observed Resident # 20 lying in bed with eyes closed.

On 2/3/2020 at 9:06 AM, the Certified Nursing Assistant (CNA) informed the surveyor that the resident was [redacted] impaired, required extensive assistance with activities of daily living (ADL), and was non-ambulatory. The CNA stated that when the resident was initially admitted to the facility, the resident had a decline in functional status as the resident was ambulatory and independent with bed mobility and transfers.

A review of the resident's Face Sheet (FS) (an admission summary), documented that the resident was admitted to the facility on [redacted] and had diagnoses which included but were not limited to [redacted]

A review of the [redacted] Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate the management of care, included a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated that the resident's cognition was [redacted] impaired. The CMDS showed that the resident required limited assistance with toileting and was independent with bed mobility, transfer, and ambulation.

A review of the [redacted] Quarterly MDS (QMDS) showed a BIMS of [redacted], which indicated that the resident was unable to complete the assessment interview, and the resident's cognition was

F 657

2) All resident care plans were audited and updated as necessary to ensure that the care plan is individualized and reflects the care provided to that resident.
Care plan policy was reviewed and updated.
3) In-servicing for all Interdisciplinary Care Team members regarding care plan review and updates for most current and accurate information to be completed by the DON.
Care Plans will be updated quarterly as per the MDS schedule and with any significant change in status. Care Plan will also be updated and reviewed at the daily clinical meeting with any changes in care or treatment.
Random sample of ten care plans will be reviewed monthly by the DON or her designee to ensure that they reflect the care and treatment provided to that particular resident.
4) Audit results will be submitted to the QAPI committee quarterly

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	315304	A. BUILDING ______ B. WING ______	02/06/2020

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F 657	Continued From page 9	F 657		

[REDACTED] impaired. The QMDS showed that the resident had experienced a significant decline in ADLs and now required total assistance with toileting, extensive assistance with bed mobility, and limited assistance with transfer and ambulation.

A review of the person-centered care plan (CP) initiated on [REDACTED], revealed that the CP had not been revised to address the decline in ADLs. The care plan indicated that the resident was independent with ambulation, bed mobility, and transfers.

On 2/4/2020 at 10:11 AM, the survey team met with the Administrator, Director of Nursing (DON), Regional Nurse and Registered Nurse/Chief Operating Officer (RN/COO), and discussed the above observations and concerns. The DON stated that the CP should have been updated to reflect the current condition resident #20.

A review of the facility policy on Care Plans, provided by the DON with an effective date of [REDACTED] indicated, "The care plan is a measure of quality of care; it gives a comprehensive picture of where the resident is at present and what is hoped to be achieved in the future," and "Perform assessments and obvious care plan updates prior to care conference."

2. On 1/28/20 at 10:30 AM, the surveyor observed Resident #72 in the room seated on a chair, reading a magazine. The surveyor observed Personal Protective Equipment (PPE) displayed by the door prior to entering the resident's room that included gloves and masks.

The surveyor reviewed Resident # 72's FS, which

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F 657	Continued From page 10	F 657		

documented that the resident was admitted to the facility on [redacted] with diagnoses that included but was not limited to [redacted]

On 1/28/20 at 10:45 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) caring for Resident#72. The LPN stated that the resident was placed on contact isolation (a type of isolation used for infections transmitted by touching the resident and surfaces that may have been contaminated in the room, preventing the spread of infection) on [redacted] when the resident's lab results were available to the facility documenting the [redacted].

The surveyor reviewed Resident #72's current CP, which was not updated to include the resident's active (current) infection that required contact isolation.

On 1/31/20 at 1:45 PM, the surveyor spoke to the Administrator, DON, and the Regional Nurse regarding the above concern.

A review of the facility's Policy and Procedure titled, "Care Plans" documented under Procedure 1-b. Part 2 - "Resident centered care plans address problems for the resident that requires individualized interventions or exceptions to protocol."

On 2/3/20 at 9:45 AM, the DON spoke to the surveyor and agreed that Resident #72's CP was not updated to match the current plan of care rendered to the resident, isolation.

3. On 1/28/20 at 10:15 AM, the surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 657	Continued From page 11	F 657		

observed Resident #34 inside the room, lying in bed and watching television. The surveyor interviewed the resident, who was alert and oriented.

The surveyor reviewed Resident #34's FS, which revealed that the resident was admitted to the facility on [redacted] and readmitted on [redacted] Further review of the Entry Tracking Minimum Data Set, an assessment tool used to facilitate the management of admission and discharges, revealed that Resident #34 was transferred to the hospital on [redacted] and readmitted on [redacted] with diagnoses that included [redacted].

The surveyor reviewed Resident #34's current CP, which was not updated to include the resident's active infection after their readmission from the hospital on [redacted], which included treatment with an [redacted]

On 2/5/20 at 11:30 AM, the surveyor spoke to the DON regarding the above concern.

A review of the facility's Policy and Procedure titled, "Care Plans" documented under Procedure 1-b. Part 2 - "Resident centered care plans address problems for the resident that requires individualized interventions or exceptions to protocol."

On 2/6/20 at 10:00 AM, the DON spoke to the surveyor and agreed that Resident #34's CP was not updated to match the current plan of care rendered to the resident after the resident was readmitted from the [redacted] on [redacted]

NJAC 8:39-11.2 (e)(1)(i)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 658	Continued From page 12	F 658		
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: Based on observation, interview, and record review, it was determined that the facility failed to follow professional standards of practice by not following the Care Plan (CP), [redacted] Recommendations, accurately administer medications ordered by a physician, and by not properly discarding medications. This deficient practice was identified for 1 of 5 residents reviewed for [redacted], Resident #59; and, 3 of 5 facility residents observed for medication pass, Resident #56, Resident #296 and Resident #79, as evidenced by the following: 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 responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." 1. On 1/28/20 at 9:40 AM, Resident #59 was observed lying in bed, eyes closed, with a sheet	F 658	F658 Services Provided meet Professional Standards 1) Resident #59 wound care recommendations were reviewed. Care Plan and CNA Kardex were updated to reflect the [redacted] care APNs recommendations. Resident #56s order for [redacted] was clarified with the attending Physician on [redacted] and the resident is receiving as ordered Resident #296 received medication as-ordered. The pill was removed from the trash and destroyed as-per facility policy. The Nurse who completed the med pass for resident #296 on 2/3/20 was re-educated regarding proper destruction of medications. The MAR/POS for resident #79 was reviewed to ensure that all previous medications were transcribed correctly from the previous months MAR/POS. Resident #50s order for [redacted] was reviewed with the attending physician on 2/5/20 and the order was clarified to state [redacted]). 2) Residents with [redacted] consults were reviewed by the unit manager and the	4/1/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	**350 OXFORD ROAD** **OXFORD, NJ 07863**

(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 658	Continued From page 13	F 658		

covering the resident's left leg. The left leg was seen resting on the surface of an mattress .

The surveyor reviewed Resident #59's Face Sheet (FS) (A one-page summary of important information about a patient) that documented the resident's diagnosis which included but was not limited to on one side)

A review of Resident #59's Minimum Data Set (MDS), a process for clinical assessment of all residents, revealed a Brief Interview for Mental Status (BIMS) of defined as having cognition.

A review of the Assessment section of the resident's medical chart included a Braden Scale sheet (an assessment tool used to predict pressure sore risk) dated documenting a score of).

Further review of Resident #59's Care Follow-Up Progress Note dated indicated an initial encounter for a The Advanced Practice Registered Nurse (APN) recommended the following treatment documented on the WPN, "Please apply) to help protect the contact with the bed." The APN also

resident care plans, CNA Kardex and TARS were updated as appropriate.
The Resident month end recaps were reviewed by nursing leadership to ensure all medications and treatments were carried over to the POS/MAR/TAR as ordered.
An audit of the medication carts/treatment carts and the POS/MAR/TAR were completed to ensure that correct medications/treatments were available in the cart.
The facility policies on Medication Administration, Transcription of Physician Orders, and Medication Monthly Recapitulation of Physician orders have been reviewed and updated.
3) The Education nurse will re-education all nurses on appropriate re-cap procedures, med pass responsibilities and following of doctors□ orders.
Weekly audits will be conducted by the unit managers to ensure that the recommendations of the Consultant are followed appropriately.
Random Monthly audits of 10 resident□s re-caps will be conducted by the DON or her designee.
Random monthly audits of 10 Resident□s medication and treatment supplies will be completed by the DON or her designee to assure medications and treatment supplies are present as ordered.
4) Audit results will be submitted to the QAPI committee quarterly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	350 OXFORD ROAD OXFORD, NJ 07863

(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 658	Continued From page 14	F 658		

indicated in the " (minimizing weight placed on a to help prevent): Facility prevention protocol." The APN recommended the above treatment recommendation and plan for off-loading the on additional visits and subsequent dated , and

Review of the dated reflected a change from the to the following, "Please consider a ," with the CP continuing with the documentation for "Offloading." The was recommended on all of the October, November, and December WPNs for the prevention of any to the

A review of the dated discontinued the treatment recommendation for the ; the had healed. However, it continued with the plan of offloading.

Resident #59's CP revealed the following, "Resident is at risk for impairment to skin integrity related to ." Interventions included in the CP, "Have off bed," which was initialed on and revised on

On 1/30/20 at 12:54 PM Resident #59 was observed lying on their back in bed with their resting on the surface of the bed, nothing was seen under the resident's for offloading.

On 1/31/20 at 11:03 AM, the surveyor observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	**350 OXFORD ROAD OXFORD, NJ 07863**

(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 658	Continued From page 15	F 658		

the Licensed Practical Nurse (LPN #1) provide wound care to Resident #59. The surveyor observed the LPN #1 place the [redacted] [redacted] on the sheet-covered air mattress and then covered Resident #59 with a sheet. The LPN#1 stated that she usually just leaves the [redacted] on top of the mattress and "that's it." The LPN#1 informed the surveyor that she does not use a pillow under the [redacted]

On 1/31/20 at 11:03 AM, the surveyor interviewed the RN Supervisor (RN), who stated that LPN #1 needed to be re-educated on offloading. The RN said that there should be a pillow under [redacted] to offload if ordered.

On 1/31/20 at 11:08 AM, the surveyor interviewed Resident #59's primary Certified Nursing Assistant (CNA), who stated that she usually places the [redacted] up on a pillow, but today did not because she knew that [redacted] care was going to be done. The CNA stated that the resident moves their [redacted] around a lot and moves their [redacted] off of the pillow.

On 2/3/20 at 9:10 AM, the surveyor observed a pillow at the foot of the bed, and the [redacted] was resting on the mattress and not off-loaded.

On 2/3/20 at 10:28 AM, during a follow-up interview with the RN, the RN informed the surveyor that the Offloading should be documented on the Treatment Administration Record (TAR). The RN, along with the surveyor, reviewed the [redacted] through [redacted] TAR, which did not have any offloading of the [redacted] [redacted] documented.

On 2/3/20 at 11:45 AM, Licensed Practical Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	**350 OXFORD ROAD OXFORD, NJ 07863**

(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 658	Continued From page 16 #2 (LPN #2) stated that she puts Resident #59's [redacted] up on a pillow, under the [redacted] so the [redacted] is offloaded. She further noted that during morning rounds, the [redacted] is sometimes off the pillow, kicked off by the resident. LPN#2 also stated that the pillow could be found at the foot of the bed or on the floor. The surveyor, along with LPN#2, searched the resident's room for the [redacted] or [redacted] [redacted] (which was recommended by the APN for prevention of injury to the resident's [redacted] belonging to Resident #59, but could not find them. LPN #2 stated that the charge nurse or the RN should review the [redacted] Care Progress Notes and update the CP to include the use of a [redacted] and [redacted]. On 2/3/20 at 12:08 PM, the surveyor interviewed the Director of Nursing (DON), who stated that the RN oversees the [redacted] Rounds. If the APN recommended a [redacted], that facility staff should have applied the [redacted] on Resident #59's [redacted]. During the interview, the DON stated that she receives a weekly [redacted] worksheet provided by the RN that includes any new APN treatment recommendations. The DON added that the RN, along with the MDS Coordinator, is responsible for updating the Care Plan. The DON informed the surveyor that the [redacted] and the [redacted] [redacted] should have been ordered for Resident #59 and that the resident's CP should have been updated to include the [redacted]. The surveyor, along with the DON, visited Resident #59's room. The DON searched the floor, the closet, all drawers, and the top of the	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	350 OXFORD ROAD OXFORD, NJ 07863

(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 658	Continued From page 17	F 658		

chest of drawers. [redacted] or [redacted] was found.

On 2/3/20 at 12:54 PM, the DON provided the contracted [redacted] Care agreement, which revealed the APN might make medical judgments including non-pharmacological therapies based on assessment; APNs may prescribe or dispense devices.

On 2/5/20 at 10:11 AM, the surveyor observed Resident #59 in bed, with their [redacted] under a sheet. LPN #1 was in the doorway of the room at this time and was asked to show the resident's [redacted] which was resting on the bed. No pillow was observed at the foot of the bed or on the floor. LPN#1 took a pillow that Resident #59 was utilizing under the resident's head and placed it under the [redacted], elevating the resident's [redacted] off of the bed.

On 2/3/2020 at 11:15 AM, the DON provided the "Skin Integrity" Policy and Procedure dated 1/7/19, which revealed the following "Policy: to maintain optimal skin integrity of each of our residents; Procedure: Any deviation in skin integrity noted during evaluation is immediately reported to the RN supervisor and an appropriate treatment implemented."

The facility provided no further documentation of offloading the left foot.

2. On 2/3/20 at 8:37 AM, during the medication pass observation, the Licensed Practical Nurse (LPN #3) assigned to Resident #56, prepared all the medications ordered by the Physician for administration to the resident. LPN #3 noted an order for [redacted] 1 capsule

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	**350 OXFORD ROAD OXFORD, NJ 07863**

(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 658	Continued From page 18 once a day for [redacted]. LPN #3 searched for the medication in the cart and stated that Resident #56 was no longer treated with [redacted]. LPN #3 informed the surveyor that she would check the Physician's orders to verify that the [redacted] been discontinued after administering Resident #56's morning medications. The surveyor reviewed the February 2020 Physician Order Sheet and found a current physician's order for [redacted] to be administered daily, with an original order date of [redacted]. The surveyor could not find a discontinue order for [redacted] On 2/3/20 at 12:22 PM, the surveyor called the Provider Pharmacy (PP), responsible for the dispensing and delivery of medications to the facility. The surveyor interviewed the Pharmacist employed by the PP, who explained that #30 doses of [redacted] were delivered to the facility on [redacted]. The facility then returned the #28 doses of [redacted] to the pharmacy on [redacted] A review of the February 2020 Medication Administration Record (MAR) revealed that nurses were signing daily, documenting that the [redacted] were administered to Resident #56 even though there was no [redacted] available in the facility for Resident #56. On 2/4/20 at 10:00 AM, the surveyor informed the Administrator and the DON who did not provide any further information to acknowledge any physician's order that discontinued the administration of [redacted] or provide	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	350 OXFORD ROAD OXFORD, NJ 07863

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F 658	Continued From page 19	F 658		

proof of [redacted] available in the facility for administration to Resident #56. The DON stated that the nurses shouldn't have been signing for the administration of [redacted] when it was not present.

3. On 2/3/20 at 9:14 AM, during the medication pass observation, the LPN #4 assigned to Resident #296 prepared the medication that included a Physician's order for [redacted] 1 tablet once a day for [redacted]. When the LPN #4 prepared the medication, it fell on top of the medication cart. The LPN #4 picked up the tablet and discarded it whole in the regular garbage attached to the medication cart.

A review of the facility's Policy and Procedure titled "Medication Administration" under Procedure #16 stated, "In the event, a medication needs to be wasted during a medication administration pass, the medication will be destroyed as outlined: a.) Non-narcotic oral medication - crush or dissolve the medication to render the medication ineffective: discard in medication trash or dispose in medication destroying solution (i.e., [redacted])."

On 2/4/20 at 10:00 AM, the surveyor informed the Administrator and DON, who both agreed, that the medication was not appropriately discarded as per their policy and procedure.

4. On 2/3/20 at 10:15 AM, during the medication pass observation, the LPN #5 assigned to Resident #79 prepared medications for administration. LPN#5 informed the surveyor that there was a discrepancy with a medication that she previously administered to Resident #79. LPN #5 told the surveyor that the February 2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	**350 OXFORD ROAD** **OXFORD, NJ 07863**

(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 658	Continued From page 20	F 658		

MAR was missing documentation of a previously administered medication, 1 capsule once a day for as a

The surveyor reviewed the February 2020 MAR with LPN #5. LPN #5 explained to the surveyor that the Physician's order for 1 capsule once a day was omitted and not transcribed onto the February 2020 MAR. LPN #5 checked the February 2020 Physician's Order Sheet, which revealed that there was a current and active Physician's Order for . LPN #5 informed the surveyor that the medication was not administered on 2/1/20 and 2/2/20, due to the omission from the February 2020 MAR.

On 2/4/20 at 10:00 AM, the surveyor informed the Administrator and the DON who could not explain why the was not transcribed to be administered onto the February 2020 MAR.

5. On 2/5/20 at 10:45 AM, the surveyor observed Resident # 50 lying in bed. The resident informed the surveyor that they had a to the receiving daily treatment by the nursing staff. The surveyor observed a on the resident's area.

On 2/5/20 at 11:00 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who performed treatment for Resident # 50. The LPN stated that the resident had a to the and received treatment daily of treatment gel).

The surveyor reviewed the February 2020 Treatment Administration Record (TAR) that documented the treatment of Resident #50's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	**350 OXFORD ROAD OXFORD, NJ 07863**

(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 658	Continued From page 21	F 658		

to the left with , cleanse with , pay dry- apply , cover with bordered gauze once daily." The TAR documented daily nursing signatures for the application of from February 1, 2020, to February 5, 2020.

Review of the February 2020 Physician's Order Form generated by the Provider Pharmacy, revealed an order dated for , cleanse with , pat dry, apply wound gel, cover with bordered gauze once daily."

The surveyor reviewed Resident # 50's FS, which revealed that the resident had a diagnosis of

The resident was assessed as cognitively intact on the QMDS dated with a documented BIMS of

The surveyor reviewed the Physician's telephone order dated for Resident #50, "Apply and cover with bordered gauze daily to . to while in bed."

The surveyor reviewed the Interdisciplinary Notes dated and documented by nursing, "Apply and cover with bordered gauze daily" to . while in bed."

The January 2020 TAR showed an order for "Cleanse with pat

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	350 OXFORD ROAD OXFORD, NJ 07863

(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 658	Continued From page 22	F 658		

dry, apply [redacted] and cover with bordered gauze daily." The TAR documented daily signatures from nursing from January 2, 2020, to January 31, 2020, that the treatment was carried out.

The order was not clarified to state what kind of [redacted] was being used.

The surveyor reviewed the Skin Integrity Report (SIR), which revealed that on [redacted], [redacted] and [redacted], the [redacted] was documented as improving by the Registered Nurse Unit Manager.

The surveyor reviewed the initial examination and follow up examinations for the [redacted] documented in the Integrated [redacted] Care [redacted] dated [redacted], [redacted], [redacted], and [redacted]. The treatment recommendations documented in the [redacted] for the initial exam and follow up exams, by the Advanced Practice Nurse (APN) all recommended applying [redacted] treatment gel) and cover with bordered gauze.

On 2/5/20 at 11:25 AM, the surveyor accompanied the LPN who cared for Resident # 50 in examining the treatment cart, which did not contain [redacted] in the cart. Further examination of the treatment cart revealed [redacted] for the use of treating Resident #50's [redacted] The LPN could not explain why the February 2020 TAR documented the application of [redacted] by nursing for treating Resident #50's [redacted] when there was none available in the cart.

On 2/5/20 at 12:03 PM, the surveyor interviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	350 OXFORD ROAD OXFORD, NJ 07863

(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 658	Continued From page 23 the DON who stated that this facility did not use [redacted] and only used [redacted] for [redacted] treatments. The DON said that the [redacted] was transcribed in error. On 2/6/20 at 9:35 AM, two surveyors observed Resident # 50 in bed during [redacted] rounds with the [redacted] APN and the Registered Nurse, Unit Manager, who cared for this resident. The APN stated that the current treatment is a [redacted] and that the [redacted] is [redacted] and healing. On 2/6/20 at 10:35 AM, the surveyor discussed the above concerns with the DON and Administrator, who had no further information to provide. NJAC: 8:39 27.1(a) NJAC 8:39- 29.2(d)	F 658		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with	F 688		4/1/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	350 OXFORD ROAD OXFORD, NJ 07863

(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 688	Continued From page 24 the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that a resident with a limited range of motion received appropriate equipment to maintain the resident's mobility. This deficient practice was identified for Resident # 32, 1 of 24 residents reviewed, and was evidenced by the following: A review of Resident # 32's Face Sheet (a one-page admission summary with important resident information) disclosed that the resident had diagnoses that included, but were not limited to [redacted] A review of the 8/7/19 Annual Minimum Data Set (AMDS) showed a Brief Interview of Mental Status (BIMS) (assessment tool used to evaluate how well someone is functioning cognitively) of [redacted], indicating that the resident's cognition was [redacted]. Review of the Special Treatments area of the AMDS documented that the resident needed a [redacted] or [redacted] assistance. A review of the Physician Orders (PO) revealed an order dated [redacted] for the [redacted] to be worn after morning (AM) care and to wear the [redacted] for four hours only.	F 688	F-688 □ Increase/Prevent decrease in ROM/mobility 1) Resident #32□s [redacted] orders were reviewed, and care plan and TAR updated to match the MD orders. 2) An audit of resident□s with [redacted] orders was completed and care plans, CNA Kardex□ s and TARS updated as appropriate. Policy titled [redacted]: Assessment, prevention and management, risk of and [redacted] Management with [redacted], [redacted] and orthotic devices were reviewed and updated 3) Nursing staff were re-educated on proper documentation and application of [redacted] Random observations by the Assistant Director of Nursing (weekly) of all residents utilizing [redacted] to ensure proper application. Monthly review of the TAR, Care Plan and CNA Kardex of all residents utilizing [redacted] to ensure proper documentation with be done by the Unit Managers and ADON. 4) Audit results will be submitted to QAPI committee quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ____ B. WING ____	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 688	Continued From page 25 A review of Resident #32's Care Plan (CP) revealed that the resident is at risk and has for self-care, which is related to [redacted] The CP documented a goal indicating that the resident will maintain the current level of function. The CP was not updated to include the [redacted] order for the [redacted] to be worn after AM care and to wear the [redacted] for four hours only. A review of Resident #32's Treatment Administration Record (TAR) from [redacted] through [redacted] lacked any documentation of a [redacted] applied after AM care. A review of the Occupational Therapy Progress Report dated [redacted], revealed a need for ongoing training with nursing staff in applying and the removal of the [redacted], and to follow the wearing schedule of the [redacted] to reduce progression [redacted] A review of the Occupational Discharge Summary dated [redacted], documented instruction and education for the nursing staff in the [redacted] orthotic schedule, to comply with the wearing schedule to address the [redacted] on the [redacted]. Review of the Quarterly Care Conference memo dated [redacted] revealed that the [redacted] was in use. On 2/5/20 at 11:36 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who cares for the resident. The CNA informed the surveyor that Resident #32 should have the [redacted] on when out of bed. The CNA added that the hand [redacted] stayed on until the resident was placed back in bed.	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 688	Continued From page 26	F 688		

On 2/5/20 at 12:11 PM, the Assistant Director of Nursing stated that the Care Plan should have been updated when the new order in [redacted] [redacted] was received. She further said that she would have expected that the [redacted] TAR would have been accurately documented, and if not applied, a progress note would have been generated by nursing.

On 2/5/20 at 2:07 PM, during an interview with the Director of Nursing (DON), the DON stated that the MDS Coordinator updates the CPs. The DON added that nurses are responsible for sharing any changes in the resident's care during the morning report with the MDS Coordinator.

On 2/6/20 at 9:24 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who cared for Resident #32. The LPN informed the surveyor that Resident #32 had a [redacted] that was to be applied by the CNA or every day after AM care and then removed after three or four hours or as tolerated. The LPN also stated that she did not recall seeing a [redacted] on the resident in November 2019, if the [redacted] was not documented on the TAR, the LPN would not know to apply it. In addition, the LPN stated that the 24-hour Chart Check nurse should have caught the [redacted] [redacted] order for the [redacted] and she should have documented it on the TAR.

On 2/6/20 at 10:11 AM, the surveyor interviewed the Director of Rehabilitation, who stated that the [redacted] applied to Resident #32 was to maintain the resident's current function.

On 2/6/19 at 10:37 AM, the DON stated that the [redacted] PO for the [redacted] was not communicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	02/06/2020

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F 688	Continued From page 27 with the nursing staff. On 2/6/20 at 10:41 AM, the DON and the Administrator met with the survey team. The DON stated that the November 2019 TAR reflected that Resident #32 was provided with the [redacted] on the 3-11 shift, but that the PO had not been transcribed properly on the TAR. The facility provided no further information. NJAC: 8:39 27.1(a)	F 688		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to obtain a Physician's Order (PO) for a resident	F 710	F-710 □ Resident Care Supervised by a Physician 1) A Physician Order for isolation was	4/1/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	350 OXFORD ROAD OXFORD, NJ 07863

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F 710	Continued From page 28 placed on isolation due to an active infection for 1 of 24 residents reviewed, Resident #72. This deficient practice was evidenced by the following: On 1/28/20 at 10:30 AM, the surveyor observed Resident #72 in the room seated on a chair, reading a magazine. The surveyor observed Personal Protective Equipment (protective clothing and other garments to protect the wearer's body from infection) (PPE) displayed by the door prior to entering the resident's room that included gloves and masks. The surveyor reviewed Resident # 72's Face Sheet (FS), (a one page summary of important information about a resident). The FS revealed that the resident had a history of diagnoses that included but was not limited to an [redacted] . On 1/28/20 at 10:45 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) caring Resident #72. The LPN stated that the resident was placed on contact isolation (a type of isolation used for infections transmitted by touching the resident and surfaces that may have been contaminated in the room, preventing the spread of infection) on [redacted] when the resident's lab results were available to the facility documenting the [redacted] The surveyor reviewed the January 2020 Physicians Order Sheet (POS), which revealed that there was no PO for contact isolation due to	F 710	received for resident #72 on [redacted] 2) All residents on Isolation were audited to ensure that physician orders were in place. The policy entitled Isolation Precautions was reviewed and updated. 3) All Nurses were re-educated by the Assistant Director of Nusing/ Education Nurse on the need for Physician orders for isolation. All residents on Isolation will be audited monthly by the ADON to ensure that Physician orders are on the chart. 4) Audit results will be submitted to the QAPI committee quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	02/06/2020

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F 710	Continued From page 29 [redacted] infection in the [redacted] for Resident #72. A Review of the Policy and Procedure titled [redacted]" section "Procedure B.#3 Medical Director shall review and implement transmission-based precautions concerning residents, visitors, and employees who are exposed to a communicable disease." The DON and Administrator were made aware that there was no PO for isolation in reference to Resident #72. On 1/31/20 at 1:45 PM, the surveyor met with the Administrator, Director of Nursing (DON), and the Regional Nurse, who stated that any resident who will be placed on any isolation must have a PO in place ordered by their physician or Advanced Practical Nurse. The DON and Administrator agreed that there was no PO order for isolation ordered and could not supply any further information as to why the isolation order was not put in place. NJAC 8:39-27.1 (b)	F 710		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any	F 756		4/1/20

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	315304	A. BUILDING ______ B. WING ______	02/06/2020

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F 756	Continued From page 30 irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the Consultant Pharmacist (CP) failed to identify facility medication irregularities, or identify/clarify ambiguous physician's orders during their monthly reviews for 2 of 24 Resident's; #56 and Resident #57; and, the facility failed to respond timely to the CP's recommendation for 1 of 24 residents reviewed; Resident #79.	F 756	F756 Drug Regimen Review, Report Irregular, Act on 1) Resident # 56s order for [redacted] was clarified with the attending physician and remains. Resident #57s [redacted] orders were clarified with the resident's attending physician and changed to PRN [redacted] hours.	

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F 756	Continued From page 31 This deficient practice was evidenced by the following:" 1. On 2/03/2020 at 8:37 AM, the surveyor observed Licensed Practical Nurse #1 (LPN #1) prepare medication for administration to Resident #56. LPN #1 informed the surveyor that there were two different orders for [redacted] documented on the February 2020 MAR; [redacted] was initially ordered daily on [redacted] and that another order [redacted] was ordered daily on [redacted] LPN #1 informed the surveyor that Vit D3 1000 units was no longer an active order and was discontinued by the physician. The surveyor reviewed the Physician's Order Sheet (POS) dated [redacted] for Resident #56, which documented a new physician's order for [redacted] one capsule daily for [redacted]. There was no documented physician's order discontinuing the administration of [redacted]. Resident #56's January 2020 Physician's Order Form (POF) signed by the physician on [redacted], documented the continuation of the physician's order for [redacted] daily ordered initially on [redacted] Resident #56's January 2020 MAR, highlighted the [redacted] order as discontinued on [redacted] by nursing. Review of the [redacted] MAR revealed that Vitamin [redacted] was no longer administered after [redacted]	F 756	Residents #57□s psychotropic drug orders for were reviewed with the [redacted] APN and remain appropriate. Resident #79□s [redacted] parameters for [redacted] where reviewed with the attending Physician and discontinued. 2) The Resident month end recaps were reviewed by nursing leadership to ensure all medications and treatments were carried over to the POS/MAR/TAR as ordered. An audit of the medication carts/treatment carts and the POS/MAR/TAR were completed to ensure that correct medications/treatments were available in the cart. Policy entitled Pharmacy Consultant was reviewed and updated. 3) Survey findings were reviewed with the Pharmacy Consultant and her supervisor. Consultant Pharmacist was re-educated by her supervisor on proper chart review and intervention. Medication reconciliation process has been updated to include forwarding the previous POS (if applicable), current POS and hospital medication records to the Pharmacy Consultant for review within 24 hours of admission. New Orders with parameters will be limited to 14 days and then re-evaluated by the physician with oversight by the Pharmacy Consultant. The Pharmacy Consultant will audit these orders monthly and include on the facility□s report. 4) Results of audits and the monthly Pharmacy Consultant reports will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	02/06/2020

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F 756	Continued From page 32	F 756	submitted to QAPI Committee monthly.	

Continued From page 32

Resident #56's Lab results dated 0 revealed a low .

On 2/3/2020 at 1:00 PM, the surveyor interviewed the Nurse Practitioner (NP), who ordered the on for Resident #56 because of the level lab results dated The NP explained that the was an additional order to be administered with the . The NP added that he never intended for the to be discontinued.

The monthly Consultant Pharmacist Evaluation (CPE) dated documented, increase The CPE did not identify that were not administered after , even though there was no written physician's order to discontinue the medication.

On 2/5/20 at 11:20 AM, the surveyor interviewed the CP who stated, "I quickly glance at the MAR. Maybe I misread the order and thought the was discontinued."

2. On 1/30/20 at 11:05 AM, the surveyor observed Resident #57 in their room seated in a wheelchair. The resident stated, "I have weak

a) The surveyor reviewed the Face Sheet (FS) (A one-page summary important information about a patient) that documented the resident's diagnosis, which included but was not limited to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	02/06/2020

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F 756	Continued From page 33	F 756		

The surveyor reviewed the hospital "After Visit Summary," a summary of medication administered to Resident #57 during the resident's hospital stay from [redacted] The "After Visit Summary" (AVS) documented that Resident #57 was treated with [redacted] mg 1 tablet by mouth every 6 hours as needed for [redacted]; ½ tablet [redacted] by mouth in the morning for [redacted] The AVS section documented, "Stop taking: [redacted]) [redacted] mg and [redacted] mg," an [redacted] and [redacted] mg," an [redacted]. Both medications were administered to Resident #57 at the facility for the treatment of the resident's [redacted] just before their 8-day hospital admission.

The surveyor reviewed the facility hospital readmission POF for Resident #57, dated [redacted] which documented a physician's order for [redacted] mg tablet: Give one tablet orally every 6 hours as needed for [redacted]" The facility failed to accurately reorder the hospital medication administered for Resident #57 with an additional routine order of [redacted] mg ½ tablet [redacted] mg) by mouth in the morning for [redacted]. The facility also did not reorder the medication previously used to treat Resident #57's [redacted] and [redacted]

The POS dated [redacted] documented a telephone order for [redacted]; Give one tablet orally twice daily at 10 AM and 4 PM for anxiety."

The facility's Interdisciplinary Notes dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 756	Continued From page 34	F 756		

[REDACTED] documented, "No signs and symptoms of anxiousness, ate dinner, fairly calm and pleasant; 4 PM dose of [REDACTED] given at 7 PM; due to prn (as needed) [REDACTED] at 3 PM."

Resident #57's Individual Patient Controlled Substance Administration Record revealed prn doses of [REDACTED] mg administered on 12/16/19, 12/17/19, 12/20/19, 12/23/19, 12/24/19, 12/31/19, 1/1/20 and 1/23/20 to the resident a few hours before or after the routine dose of [REDACTED] mg (administered routinely at 10 AM and 4 PM) without regard to the [REDACTED] [REDACTED] prn every 6-hour directions.

On 1/29/20 at 10:15 AM, the surveyor interviewed the Licensed Practical Nurse #2 (LPN #2), who administered medications and cared for Resident #57. LPN #2 stated that she would wait 6 hours before administering doses of [REDACTED]

The monthly CPE, dated [REDACTED] documents, "Readmit-meds noted." The CP did not alert the facility that there is a discrepancy between the hospital order for [REDACTED] and the facility order upon readmission (omission of [REDACTED] [REDACTED] mg ½ tablet (0.25 mg) by mouth in the morning for [REDACTED]).

The CP did not request clarification of administration from the physician that a routine order for [REDACTED] mg at 10 AM and 4 PM for [REDACTED] (already every 6 hours) was added on 12/11/19, in addition to the already existing order for [REDACTED] mg every 6 hours prn for [REDACTED].

The CP did not alert the facility that if the routine and all prn doses of [REDACTED] mg were administered to Resident #57, the dosage would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 756	Continued From page 35 exceed the recommended daily dose of in patients over of age. The surveyor interviewed the facility CP 2/3/20 at 10:31 AM. The CP stated that she viewed the routine order for mg for and the prn order for mg for as two different and separately running Physicians ' orders. The CP further stated that the prn mg Physician's order could be administered without regard to the dosing of the routine mg. The CP said that she did not feel the need to inform the facility that there might be duplication of dosing or ask the facility to clarify the two orders with the physician. The CP also indicated that she did not need to alert the facility that if the routine and prn doses of mg were administered together to Resident #57, the dosage would exceed the recommended daily dose of in patients over of age. The surveyor interviewed Resident #57's Physician on at 1:38 PM by telephone, concerning both routine and prn orders for mg ordered for anxiety. The physician stated that he did not realize the duplication of the orders and would want the administration of each dose of mg, whether routine or prn separated by 6 hours. b) Resident #57 was admitted to the facility with a diagnosis that included but was not limited to , , and . Resident #57 was treated with and . Upon readmission from a hospital stay, the and were not reordered (discontinued at the hospital). The CP did not alert the physician or the facility to	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	02/06/2020

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F 756	Continued From page 36	F 756		

review the discontinuation of Resident #57's [redacted] and [redacted] in the hospital. The CP did not request an explanation of why the medications were not reordered when readmitted to the facility.

The surveyor interviewed the facility CP [redacted] at 10:31 AM, who stated that she does not compare hospital orders to facility readmission orders. She also said that she did not notice that the [redacted] and [redacted] had not been reordered for Resident #57 upon readmission from the hospital on 11/23/19.

3. On 1/28/20 at 9:54 AM, the surveyor observed Resident #79 lying in bed, awake, and smiling.

The surveyor reviewed the FS that documented the resident's diagnosis, which included but was not limited to [redacted].

The surveyor reviewed the physician's order dated [redacted] and reordered upon readmission from the hospital on [redacted] for [redacted] [redacted] mg (1) tablet daily hold if [redacted] [redacted] is less than [redacted]

The Medication Administration Record (MAR) dated 11/2019, 12/2019, and 1/2020 did not document all [redacted] [redacted]

The 11/2019 MAR had 26 omitted SBP levels for the month. The 12/19 MAR had 11 omitted [redacted] [redacted] for the month. The 1/2020 MAR had two omitted [redacted] [redacted] for the month.

The 1/2020 MAR documented four administered doses when the [redacted] was less than [redacted] the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	02/06/2020

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F 756	Continued From page 37	F 756		

medication should not have been administered. The medication was administered on 1/17/20 when the [redacted] was documented as [redacted], 1/18/20 when the [redacted] was recorded as [redacted], 1/19/20 [redacted] [redacted], and 1/20/20 when the [redacted] was documented as level [redacted]

The CPE dated [redacted] documented a comment, [redacted] document [redacted] [redacted] Monitor." Further review of the "Consultant Pharmacist's Monthly Report" dated [redacted] and referring to Resident #79 requests, stated, "Please make sure nurses are documenting the [redacted] each day-there have been blanks for many days in a row this month." Review of the "Action Taken" section of the Consultant Pharmacist ' s Monthly Report," dated [redacted], did not have a physician's response to this recommendation, and there was no follow up by the physician or facility.

Further review of the CPE documents revealed that the CP reviewed Resident #79's medication on [redacted] and then on [redacted] with no additional documentation of the discrepancy from the CP, and no follow up from the facility.

The Administrative Policy and Procedures for Consultant Pharmacist (P&P CP) during regular monthly visits with an effective date of [redacted] documents, "The Consultant Pharmacist will review all residents' medical records, including any new admissions, readmissions present in the facility, during the regular monthly visit."
In addition, the P&P CP documented, "The Consultant Pharmacist shall identify, document and report actual and potential irregularities for review and action to the Director of Nursing and physician's (where appropriate). Also, "The

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F 756	Continued From page 38 nursing and attending Physician (or licensed designee) shall respond to the recommendations in a timely manner per facility policy for non-urgent recommendations." On 2/3/20 at 2:30 PM, the surveyor discussed the CP discrepancies with the Director of Nursing and the Administrator. The DON stated that there was no follow up on the documented issues by the CP to the facility. There was no further information supplied to explain why the facility did not act upon the CP's recommendation. NJAC 8:39- 11.2 (d)	F 756		
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	F 842		4/1/20

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F 842	Continued From page 39 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 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;	F 842		

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F 842	Continued From page 40 (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: Based on observation, interview, and record review, it was determined that the facility failed to systematically organize records for 1 of 24 residents reviewed, Resident #20. This deficient practice was evidenced by the following: On 1/28/2020 at 9:44 AM, during the initial tour, the surveyor observed Resident #20 lying in bed with eyes closed. A review of the resident's Face Sheet (FS), an admission summary, documented that the resident had diagnoses which included but were not limited to [redacted] A review of the 10/16/19 Quarterly Minimum Data Set (QMDS) revealed a Brief Interview of Mental Status (BIMS), an assessment tool used to facilitate the management of care, [redacted] which indicated that the resident's cognition was [redacted] impaired. The QMDS noted that the resident required total assistance with toileting, extensive assistance with bed mobility, and limited assistance with transfer and ambulation. A review of the resident's complete medical records revealed that there was no documented evidence that the ADL assessment was done by a	F 842	F842 □ Resident Records □ Identifiable Information 1) Resident #20□s ADL documentation has been added to our Electronic Medical Record (EMR) under the Point of Care (POC) section. 2) All Resident ADL documentation is included in our EMR under the POC section. 3) All CNA□s will be re-in-service by the ADON/Education Nurse on proper ADL documentation. Unit Managers and Supervisors will be in serviced by the DON on monitoring of ADL documentation in Point of Care and running exception reports. Random documentation audits (2X per week) will be completed at end of shift by the Unit Managers/ Supervisors/Charge Nurses to ensure ADL documentation is compliant. ADL exception reports will be reviewed at morning report daily by the DON or her designee to ensure ADL documentation remains compliant 4) Results of audits will be submitted to QAPI committee quarterly.	

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F 842	Continued From page 41	F 842		

Certified Nursing Assistant (CNA) from September 2019 through December 2019.

On 2/3/2020 at 9:00 AM, the surveyor asked the Assistant Director of Nursing (ADON) for a copy of the CNA's accountability with regards to ADL records from July 2019 through January 2020. The ADON stated that she would get back to the surveyor because she had to ask the Director of Nursing (DON).

On 2/4/2020 at 9:14 AM, the surveyor asked the DON for the ADL records belonging to Resident #20 from July 2019 through January 2020. The DON stated that she would get back to the surveyor because the Medical Record person was on leave and "I can't find the records."

On 2/4/2020 at 10:11 AM, the survey team met with the Administrator, DON, Regional Nurse, and Registered Nurse/Chief Operating Officer (RN/COO) and discussed the above concerns.

On 2/5/2020 at 9:40 AM, the survey team met with the DON, who stated, "I still cannot find the information that you're looking for" regarding the ADL records for the resident. The DON further stated that the nurses documented and assessed the resident's ADLs. The DON said she would locate and provide the surveyor with a copy of the nurse's notes.

On 2/5/2020 at 12:22 PM, the DON informed the surveyors that there was no CNA or Nurse's ADL documentation for July, October, November, and December 2019. She further stated that there were nurses notes located for August 2019, and then added, "the January 2020 ADL records were not completed."

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F 842	Continued From page 42 The facility Documentation Policy and Procedure provided by the DON with an effective date of 1/1/17 stated, "Documentation is a professional tracking to enhance the continuity of care." And, that the Policy included: "All members of the interdisciplinary team (licensed nursing staff, consulting professionals, specialized rehab therapists, dieticians, social service staff, activity staff) who provide care and services to the residents; data collection to establish need for assessment or re-assessment." On 2/6/2020 at 10:33 AM, the survey team met with the Administrator, DON, Regional Nurse and RN/COO. The DON stated that there was no additional information available and that Resident # 20's assessment was not completed. NJAC 8:39- 35.2	F 842		