STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	**1302 LAUREL OAK ROAD VOORHEES, NJ 08043**

(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 125430, NJ 125438 CENSUS: 185 SAMPLE SIZE: 4 F600 IJ Based on interviews, Medical Record (MR) review, and review of other pertinent facility documentation on 6/28/19 and 7/2/19, it was determined that the facility failed to provide the services necessary to avoid physical harm. Specifically, the facility neglected to provide sufficient supervision of a resident (Resident #2) with a known history of [redacted] and a history of [redacted], who on [redacted], had [redacted] and was sent to the [redacted] is Center and returned to the facility the same day. After readmission, the facility failed to monitor Resident #2 for medication effectiveness and side effects and failed to have the [redacted] see the resident after a visit to [redacted] according to the Physician's Orders (PO), and failed to provide supervision in accordance with the "Pre-Admission Screening and Resident Review Leve[redacted] (PASRR)" recommendations. In addition, the facility failed to update the Resident's care plan (CP) to reflect the PASRR recommendations and to provide staff training and education for [redacted]. The facility staff also failed to follow the facility's own policies titled "[redacted]," "Care Plan-IDT," "Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property" for 1 of 4 sampled	F 000		

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

Electronically Signed | 08/23/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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	Continued From page 1	F 000		

residents (Resident #2). On [redacted], Resident #2 was found on the bathroom floor unresponsive with a [redacted] next to him/her and died of an apparent [redacted] at the Facility. This placed Resident #2, as well as all other residents at risk for [redacted], in an Immediate Jeopardy (IJ) situation. This IJ ran from 4/15/19 through 5/23/19 when the resident was found. The IJ was identified and reported to the Administrator and the Director of Nursing on 7/2/19 at 2:36 p.m. The IJ was lifted that same day at 4:16 p.m., when the facility provided an acceptable Removal Plan.

F689 IJ

Based on interviews, Medical Record (MR) review, and review of other pertinent facility documentation on 6/28/19, and 7/2/19, it was determined that the facility staff failed to consistently monitor and/or supervise residents for safety to prevent [redacted] and/or [redacted] for 3 of 3 sampled residents reviewed for [redacted] (Resident #2, Resident #3, and Resident #4). Specifically, the facility failed to monitor Resident #2 consistently, with a known history of [redacted], who on [redacted], was sent to [redacted] Emergency Room for verbalizing [redacted], and upon return to the facility the staff failed to ensure a safety plan was in place. On [redacted], Resident #2 was found unresponsive in the bathroom with a [redacted] and [redacted] next to the body and pronounced dead at the Facility. In addition, the facility staff failed to consistently monitor Resident #3 who was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	**1302 LAUREL OAK ROAD VOORHEES, NJ 08043**

(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	Continued From page 2 allowed to [redacted]) with a known history of [redacted], brought [redacted] into the facility. The police were called when a staff member observed [redacted] being passed from Resident #3 to Resident #4 on [redacted] Resident #4 admitted Resident #3 gave him/her [redacted]. The facility failed to implement interventions for Resident #3 until [redacted] when the resident's [redacted] privileges were [redacted] and, [redacted] was changed to [redacted]. In addition, the facility staff failed to follow the facility's Policies titled "Incident and Accident" and "[redacted]," for 3 of the 4 sampled residents (Resident #2, Resident #3 and Resident #4). This placed Resident #2, as well as all other residents at risk for [redacted] and/or [redacted], in an Immediate Jeopardy (IJ) situation. The IJ ran from 4/15/19 until 6/28/19, when the alleged provider of [redacted] was no longer allowed to go OOP and had supervised visitors. The Administrator and the Director of Nursing were notified of the IJ on 7/2/19 at 2:36 p.m. and were provided the IJ template. The IJ was lifted that same day when the facility provided an acceptable Removal Plan at 4:16 p.m.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		7/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	**1302 LAUREL OAK ROAD VOORHEES, NJ 08043**

(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 600	Continued From page 3 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: COMPLAINT: # NJ 125430, NJ 125438 REVISED 2567 Based on interviews, Medical Record (MR) review, and review of other pertinent facility documentation on 6/28/19 and 7/2/19, it was determined that the facility failed to provide the services necessary to avoid physical harm. Specifically, the facility neglected to provide sufficient supervision of a resident (Resident #2) with a known history of [redacted] and a history of [redacted], who on [redacted], had [redacted] and was sent to the [redacted] Center and returned to the facility the same day. After readmission, the facility failed to monitor Resident #2 for medication effectiveness and side effects and failed to have the [redacted] see the resident after a visit to [redacted] according to the Physician's Orders (PO), and failed to provide supervision in accordance with the "Pre-Admission Screening and Resident Review Level [redacted] (PASRR)" recommendations. In addition, the facility failed to update the Resident's care plan (CP) to reflect the PASRR recommendations and to provide staff training and education for [redacted] The facility staff also failed to follow the facility's own policies titled [redacted]," "Care Plan-IDT," "Abuse, Neglect, Exploitation, Mistreatment and Misappropriation	F 600	F600 1. Resident #2 is no longer at the facility. 2. Facility will review to identify any other Residents with [redacted] and history of [redacted] Further review will be conducted to ensure [redacted] services are in place and the care plans have appropriate intervention in place and Resident safety is maintained. 3. All nursing staff will be educated on [redacted] and [redacted], and will be educated on how to implement appropriate plan of care for identified Residents. Policy and Procedure for [redacted] will be reviewed, updated and to maintain Resident safety.. 4. Director of Nursing or Designee will review admitted Residents who have diagnosis of [redacted] ideation to ensure orders for services are in place and carried out and reported in QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	**1302 LAUREL OAK ROAD VOORHEES, NJ 08043**

(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 600	Continued From page 4	F 600		

of Resident Property" for 1 of 4 sampled residents (Resident #2). On [redacted], Resident #2 was found on the bathroom floor unresponsive with a [redacted] next to him/her and died of an apparent [redacted] at the Facility. This placed Resident #2, as well as all other residents at risk for [redacted], in an Immediate Jeopardy (IJ) situation. This IJ ran from 4/15/19 through 5/23/19 when the resident was found. The IJ was identified and reported to the Administrator and the Director of Nursing on 7/2/19 at 2:36 p.m. The IJ was lifted that same day at 4:16 p.m., when the facility provided an acceptable Removal Plan. This deficient practice was evidenced by the following:

1. According to the "Admission Record" (AR), Resident #2 was originally admitted to the facility on [redacted] and readmitted on [redacted], with diagnoses which included but were not limited to: [redacted].

According to the Minimum Data Set (MDS), an assessment tool dated [redacted] Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident was cognitively [redacted] The MDS also indicated Resident #2 required limited to extensive assistance with Activities of Daily Living (ADLs).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 600	Continued From page 5	F 600		

Review of Resident #2's Care Plan (CP) with a "Created on" date of [redacted] revealed the following under "Focus" [redacted] related to on [sic] the process of divorce and no place to go home; history of [redacted] of an [redacted]." In addition under "Focus" was [redacted]," however, there was no documentation under "Goal" or under "Interventions." The CP did not address Resident #2's high risk for [redacted] to his/her past history of [redacted] or include interventions related to the history of [redacted]

According to a hospital document titled "Hospitalist Daily Progress Note," dated [redacted] at 4:49 p.m., the medical doctor documented in his progress note the following under "Plan" [redacted], patient has been evaluated by [redacted] and they are recommending that he/she has [redacted] placement due to his/her [redacted]

In addition, hospital documentation by the Social Worker (SW) dated [redacted] Resident's #2 family expressed the following to the SW: Concern that an [redacted] of this extent "had to be" a [redacted]t and expressed concern that the patient was "[redacted]," and was concerned about losing their house, and the unstable relationship with their [redacted]

Review of Resident #2's "Pre-Admission Screening and Resident Review (PASRR) Level Screen dated [redacted]9, a tool used to identify individuals that are diagnosed or suspected of having Mental Illness (MI), developmental disability (DD), intellectual disability (ID), or related conditions, revealed a [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 600	Continued From page 6	F 600		

under [redacted] indicating Resident #2 had a [redacted]. Recommendations to "Refer to the [redacted]. Nursing Facility Admission is Contingent upon receipt of [redacted] evaluation and determination."

Review of Resident #2's Facility "Progress Notes" (PN) dated [redacted] at 10:46 a.m., written by the Nurse Practitioner (NP), revealed the following documentation: The patient noted to have [redacted] in the past. In addition, under "Assessment and Plans" Intentional [redacted]: patient was cleared by [redacted] and discharge to [redacted]). He/she is appropriate and calm at this time. [redacted] consult at rehab.

Review of the [redacted] Consultation document titled "Adult and Geriatric [redacted] Evaluation" dated [redacted] revealed the following: Past [redacted] History; [redacted].
Mental Status Exam: [redacted].
Under [redacted] titled "Summary of Placement and Treatment Recommendations" included; [redacted] Medication Monitoring, and Supportive Counseling.

Review of Resident #2's Care Plan (CP) dated [redacted], under "Focus" [redacted] revealed the following: " Sent to .. [redacted] center for evaluation d/t (due to) verbalization of [redacted]
Under "Interventions" dated [redacted], listed the following: Allow resident to choose activity of interest daily. Engage resident in conversation daily. Provide activity calendar. No additional interventions were listed for Resident #2's safety

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 600	Continued From page 7 following the [redacted] visit for [redacted] According to the PN dated [redacted] at 12:11 p.m., [redacted] at 9:30 p.m., [redacted] at 6:22 p.m., and [redacted] at 9:27 a.m., the NP wrote under "Assessment and Plan:" section #15 '[redacted] F/U (follow up) with [redacted] According to the "Physician's Orders" dated [redacted], Resident #2 was restarted on [redacted] [redacted] (milligrams) once a day for [redacted]. No documentation was available to show the resident was monitored for medication side effects and/or effectiveness of the [redacted] Review of the facility document titled '[redacted] Monthly Review" with a meeting date of [redacted] 9, showed "Target behavior" of '[redacted] listed under "# of Episodes" was zero. No additiona[redacted] Monthly Review documents were made available. Review of Resident #2's "PASRR Level[redacted] Determination Notification" dated [redacted], revealed the following: The above-named client has mental health treatment needs that can be met in a Nursing Facility. The following recommendations are being made for the client: [redacted] consult upon admission to Nursing Facility. Routine follow up visits with Primary Care Physician and [redacted] Medication monitoring. [redacted] Counseling. Routine Laboratory Testing. Formulate and implement a behavioral modification plan to	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 600	Continued From page 8	F 600		

address any behavioral disturbances. Provide education to client and family on [redacted] and medication. Develop a [redacted] Intervention/Safety Plan with the client.

According to the Facility's Reportable Event Record/Report (FRE) dated [redacted] with an event date of [redacted] and a "Time of Event" of 14:10 (2:10 p.m.), revealed the following: Type of incident: "Unexpected Death:" Resident #2 was found by the housekeeper on the bathroom floor in their room during routine cleaning. The nurse was notified. Nursing reported resident was unresponsive and one [redacted] was next to his/her body. [redacted] was initiated and 911 was called. Narcan was administered. Paramedics arrived and continued [redacted] Facility doctor pronounced Resident #2 dead at 2:24 p.m. Medical Examiner removed the body and the facility is waiting on autopsy results.

During an interview on 6/28/19 at 2:25 p.m., the DON stated Resident #2 was not seen by the [redacted] on [redacted] because "she was here just for the monthly review with the team." In addition, the DON was not sure if the [redacted] was notified that Resident #2 was sent to [redacted] on [redacted] for [redacted].

Review of an email dated June 28, 2019 at 5:28 p.m., the DON stated; The target behavior was zero because it was the review for [redacted], not [redacted] The [redacted] happened on [redacted] and the meeting which was supposed to be held at the end [redacted] to discuss for the month of [redacted] was postponed to [redacted]. Resident #2 was not included since [redacted] was already deceased at that time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 600	Continued From page 9 During an interview on 7/2/19 at 12:32 p.m., the ADON stated, "The staff here are not in-serviced on [redacted] or [redacted] just on safety." The ADON also stated "he/she (Resident #2) was being closely monitored for 72 hours after returning from the [redacted] Center. [redacted]) would be helpful here however, if they (residents) have [redacted] we send them out." Review of Resident #2's "Progress Notes" revealed staff monitored the resident for safety every [redacted] minutes on [redacted], every [redacted] minutes on [redacted], hourly checks on [redacted] and [redacted] and [redacted] on [redacted] No additional safety monitoring was documented in the progress notes by the nursing staff. During a phone interview on 7/2/19 at 1:40 p.m., the [redacted] said she was notified Resident #2 went to [redacted] and returned the same day. In addition, she stated "I'm in the Facility every week, and monthly we do review of [redacted] medications. I don't know why I did not see him/her on [redacted] I guess because [redacted] just came back from the hospital. No one expressed concerns to me" (regarding Resident #2). She further stated, she felt the facility was equipped to handle residents with history [redacted] "It was an [redacted] per the hospital record. So yes, they were okay to handle him/her." Review of the facility's policy titled [redacted] " with a creation date of 02/2014, and a "last reviewed" date of 02/2019, revealed the following under "Policy" "It is the policy of this facility to ensure that residents/patients who voice	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 600	Continued From page 10	F 600		

and/or display [redacted] actions receive services and interventions to help them manage feelings and maintain their psychosocial well-being." In addition, under "Procedure" section #9. Monitor resident/patient closely. Enlist assistance of other staff members to "look in" on resident/patient. Section #11. When the resident is no longer considered [redacted], the facility will develop a precautionary plan. This will ensure the provision of ongoing monitoring and assessment of the resident's mood status and interventions.

Review of the facility's policy titled "Care Plan - IDT" with a "last reviewed" date of 03/2019, revealed the following under "Procedure" section #2. "Care Plans" "Interim care plan:" High-risk areas such as fall, wounds, pain, safety... must be care planned immediately upon identifying risk via evaluation.

Review of the facility's policy titled "Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property" with a created date of 05-19 (May 2019), revealed the following: Under "Centers for Medicaid and Medicare Services [sic] (CMS) - Definitions. Under subtitle "Definitions of Abuse and Neglect" section f. "Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress."

N.J.A.C. 8:39-4.1 (a) (5)

This deficiency continues at a D level.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 657 SS=E	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: COMPLAINT: # NJ 125430, NJ 125438 Based on interviews, Medical Record (MR) review, and review of other pertinent facility documentation on 6/28/19 and 7/2/19, it was determined that the facility staff failed to update	F 657	1. Resident #2 and #3 are no longer in the facility and #4 care plan has been reviewed and updated. 2. All Residents with [redacted] history of [redacted] diagnosis as well as PASSR level [redacted] have the potential to be affected. The facility will	8/30/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 657	Continued From page 12 and/or implement a Care Plan (CP) to address the needs of the residents to include a "Focus" of [redacted], and/or implement safety interventions for 3 of 4 sampled residents (Resident #2, Resident #3, and Resident #4), as well as address the PASRR recommendations for 1 of 4 sampled residents (Resident #2), and failed to follow the facility's policy titled "Care Plan - IDT." This deficient practice was evidenced by the following: 1. According to the "Admission Record" (AR), Resident #2 was originally admitted to the facility on [redacted], and readmitted on [redacted] with diagnoses which included but were not limited to: [redacted]. According to the Minimum Data Set (MDs), an assessment tool dated [redacted] Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident was cognitively [redacted]. The MDS also indicated Resident #2 required limited to extensive assistance with Activities of Daily Living (ADLs). Review of Resident #2's Care Plan (CP) with a "Created on" date of [redacted] revealed the following under "Focus" [redacted] related to on [sic] the process of [redacted] and no place to go [redacted] " In addition under "Focus" was [redacted] " however there was no documentation under "Goal" or under "Interventions." The CP did not address Resident #2's high risk for [redacted] to his/her	F 657	review all medical records to identify any [redacted] diagnosis to ensure they have care-plan focus and safety intervention in place. In addition all current Residents with PASSR level[redacted] will be reviewed to ensure all recommendations are carried out and care-planned. 3. Policy-Care Plan- IDT will reviewed. All nurses will be re-educated on the care planning process with particular focus on [redacted] conditions, [redacted] and interventions for resident safety. Social Services will be re-educated on the PASSR[redacted] and follow up on the accompanying recommendations. 4. DON or Designee will review the care plans of all new Residents with [redacted] history to ensure appropriate care plans including safety measures are in place. All new PASSR[redacted] be reviewed by the DON or designee to ensure the recommendations were implemented on the resident care plans. The results of these reviews will be presented to the QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 657	Continued From page 13 past history of [redacted] or include interventions related to the history of [redacted] Review of Resident # 2's "Pre-Admission Screening and Resident Review (PASRR) [redacted] Screen dated [redacted], a tool used to identify individuals that are diagnosed or suspected of having Mental Illness (MI), developmental disability (DD), intellectual disability (ID) or related conditions (RC), revealed a [redacted] under [redacted] indicating Resident #2 had a [redacted] Recommendations to "Refer to th [redacted] "Nursing Facility Admission is Contingent upon receipt of [redacted] evaluation and determination." Review of Resident #2's "PASRR Level [redacted] Determination Notification" dated [redacted] revealed the following: The above-named client has [redacted] treatment needs that can be met in a Nursing Facility. The following recommendations are being made for the client: [redacted] consult upon admission to Nursing Facility. Routine follow up visits with Primary Care Physician and [redacted] t. Medication monitoring. [redacted] Counseling. Routine Laboratory Testing. Formulate and implement a behavioral modification plan to address any behavioral disturbances. Provide education to client and family on [redacted] and medication. Develop a [redacted] Intervention/Safety Plan with the client. None of the above recommendations were addressed and/or included on the residents CP. During an interview on 7/2/19 at 12:32 p.m., the	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 657	Continued From page 14 ADON stated; The Care Plan is a document that we should be following. We failed to document properly, and we failed to update the Care Plan properly." 2. According to the "Admission Record" (AR), Resident #3 was originally admitted to the facility on [redacted] with diagnoses which included but were not limited to: [redacted] According to the Minimum Data Set (MDs), an assessment tool dated [redacted], Resident #3 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the Resident was cognitively [redacted]. The MDS also indicated Resident #3 required limited assistance for Activities of Daily Living (ADLs). According to the "Investigation Report" date of Incident [redacted], Resident #3 was observed by a staff member passing a [redacted] with [redacted] inside to another resident (Resident #4). The administration was notified, and the police were called. Resident #3 admitted to distributing [redacted] to Resident #4. Review of the Care Plan for Resident #3 showed a "Focus" of [redacted], on [redacted] treatment." New interventions for safety were not put in place after the [redacted] incident on [redacted], unti[redacted] 3. According to the "Admission Record" (AR), Resident #4 was originally admitted to the facility on [redacted] and readmitted on [redacted], with diagnoses which included but were not limited to: [redacted]	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 657	Continued From page 15 Weakness. According to the Minimum Data Set (MDs), an assessment tool dated [redacted], Resident #4 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the Resident was cognitively [redacted]. The MDS also indicated Resident #4 required limited assistance for Activities of Daily Living (ADLs). Review of Resident's #4's [redacted] Evaluation dated [redacted], showed under section "Past [redacted] History" [redacted] Review of Resident #4's progress notes dated [redacted] at 3:42 p.m., written by the Nurse Practitioner (NP) showed a history of "[redacted] ([redacted]). Review of Resident #4's Care Plan showed the following: under Focus: "[redacted]" Resident's #4's CP did not address safety interventions related to the resident's history of [redacted] During an interview on 7/2/19 at 2:10 p.m., Resident #4 stated he/she is a [redacted] and was on [redacted] prior to admission at this facility a year and a half ago. Review of the facility's policy titled "Care Plan - IDT" dated 3-2019 (March 2019), revealed the following under "Policy" "The plan of care must describe the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and social well-being. Interim care plans are developed within twenty-four (24) hours of admission for high-risk problems, including major medications	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 657	Continued From page 16 or diagnosis...." Under section 2b. "High-risk area such as ...safety ...must be care planned immediately upon identifying risk via evaluation."	F 657		
F 689 SS=K	N.J.A.C. 8:39-11.2(e) (1) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: COMPLAINT: # NJ 125430, NJ 125438 REVISED 2567 Based on interviews, Medical Record (MR) review, and review of other pertinent facility documentation on 6/28/19, and 7/2/19, it was determined that the facility staff failed to consistently monitor and/or supervise residents for safety to prevent [redacted] for 3 of 3 sampled residents reviewed for [redacted] (Resident #2, Resident #3, and Resident #4). Specifically, the facility failed to monitor Resident #2 consistently, with a known history of [redacted], who on [redacted] was sent to [redacted] Emergency Room for verbalizing [redacted], and upon return to the facility	F 689	1. Resident #2 and #3 are no longer at the facility. Resident#4 is on close monitoring for substance abuse tendencies. 2. Facility will review to identify any other Residents with [redacted], and/or attempts of [redacted]. Further review will be conducted to ensure [redacted] services are in place and the care plans have appropriate intervention in place. Ensure residents are consistently monitored and supervised. 3. All nursing staff will be educated on signs and symptoms and appropriate action to take when noted of [redacted]	7/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 689	Continued From page 17 the staff failed to ensure a safety plan was in place. On 5/23/19, Resident #2 was found unresponsive in the bathroom with a [redacted] and [redacted] next to the body and pronounced dead at the Facility. In addition, the facility staff failed to consistently monitor Resident #3 who was allowed to go[redacted]) with a known history of [redacted], brought [redacted] into the facility. The police were called when a staff member observed [redacted] being [redacted] 6/21/19. Resident #4 admitted Resident #3 gave him/her [redacted] The facility failed to implement interventions for Resident #3 until [redacted]9 when the resident's [redacted] were [redacted] and, [redacted] was changed to [redacted]. In addition, the facility staff failed to follow the facility's Policies titled "Incident and Accident" and "[redacted]," for 3 of the 4 sampled residents (Resident #2, Resident #3 and Resident #4). This placed Resident #2, as well as all other residents at risk for [redacted], in an Immediate Jeopardy (IJ) situation. The IJ ran from 4/15/19 until 6/28/19, when the alleged provider of [redacted] was no longer allowed [redacted] and had [redacted]. The Administrator and the Director of Nursing were notified of the IJ on 7/2/19 at 2:36 p.m. and were provided the IJ template. The IJ was lifted that same day when the facility provided an acceptable Removal Plan at 4:16 p.m. This deficient practice was evidenced by the following: 1. According to the "Admission Record" (AR), Resident #2 was originally admitted to the facility on [redacted] and readmitted on [redacted], with	F 689	over dose and suicidal ideation. Will review policy and procedure on [redacted]. 4. Director of Nursing or Designee will review daily shift report to ensure consistent monitoring is in place for those residents at risk for [redacted] and [redacted] and reported in QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 689	Continued From page 18 diagnoses which included but were not limited to: [redacted] According to the Minimum Data Set (MDs), an assessment tool dated [redacted] Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the Resident was cognitively [redacted]. The MDS also indicated Resident #2 required limited to extensive assistance for Activities of Daily Living (ADLs). Review of Resident #2's Care Plan (CP) revealed under "Focus" a diagnosis of [redacted] related to the process of [redacted] and no place to go home; history of [redacted] dated [redacted]. "Sent to [redacted] Center for evaluation d/t (due to) verbalization [redacted]." The CP was updated with the following interventions after Resident #2's visit to [redacted]: Allow resident to choose activity of interest daily. Engaged resident in conversation daily. Provide activity calendar. However, the CP did not include interventions for safety after the visit to [redacted] on [redacted] Review of the "Progress Notes" (PN) dated [redacted] at 10:46 a.m., written by the Nurse Practitioner (NP) revealed the following: ...history of [redacted].... The patient noted to have [redacted] in the past. Review of [redacted] Center Discharge Instructions dated [redacted], revealed under "Medical Instructions" the diagnoses of [redacted]	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 689	Continued From page 19	F 689		

[redacted]." This can interfere with work and relationships. In addition, the [redacted] Some have [redacted] at this stage. [redacted].

Review of Resident #2's "Progress Notes" revealed staff monitored the resident for safety every [redacted] minutes on [redacted] every [redacted] minutes on [redacted], [redacted] checks on [redacted] and [redacted], and [redacted] on [redacted] However no additional safety monitoring was done.

During an interview on 7/2/19 at 12:32 p.m., the ADON stated "The resident was being monitored after he/she returned from [redacted] by the nursing staff [redacted] minute checks for 72 hours then it was discontinued. They (the nursing staff) should have done additional [redacted] checks and they should have put it on the Care Plan (CP). The Care Plan is a document that we should be following. We failed to document properly, and we failed to update the Care Plan properly." In addition, the ADON agreed that during the monthly [redacted]) review on [redacted] the team should have discussed Resident's #2 [redacted] visit on [redacted] and the [redacted] should have seen the Resident at that time. The ADON also stated "The Social Worker should have done 1 to 1 with the resident and she should have included the [redacted] to be involved with his care."

2. According to the "Admission Record" (AR),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 689	Continued From page 20 Resident #3 was originally admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted] According to the Minimum Data Set (MDs), an assessment tool dated [redacted], Resident #3 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the Resident was cognitively [redacted]. The MDS also indicated Resident #2 required limited assistance for Activities of Daily Living (ADLs). Review of the Care Plan for Resident #3 showed a "Focus" of [redacted] Disorder, on [redacted] treatment." Interventions initiated on [redacted] included: 1. Administer [redacted] daily as ordered. 2. Educate resident about the indication for treatment, goals of therapy and the importance of compliance with the program. 3. Monitor for side effects with use of [redacted] such as respiratory depression, black tarry stools, bleeding gums, blood in urine, blurred vision, and inform MD (Medical doctor) for prompt management. According to the Facility's "Investigation Report" On [redacted] at approximately 11:00 a.m., Resident #3 was observed by a staff member dropping a [redacted] into Resident #4's [redacted] Upon emptying the [redacted] the staff observed a [redacted] with blue paper and [redacted] inside. The Administrator, Director of Nursing (DON), and Social Worker were notified. The DON contacted the Police Department and a Police Detective was sent to the Facility to investigate. The detective interviewed the residents involved. Resident #4 admitted	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 689	Continued From page 21	F 689		

Resident #3 placed an [redacted] into their [redacted]. Resident #3 admitted to [redacted] to Resident #4. The [redacted] was given to the Detective and Resident #3 was taken to the Police Station for questioning and admitted to obtaining the [redacted] from an associate near the [redacted] Clinic during the recent visit there.

Further review of the Investigation Report showed the following under "Interventions" Social services continued to provide emotional support to both residents. Resident #3 is not allowed to have visitors in their room, all visits must be supervised at all times. Resident #3 will not be going to the Clinic. [redacted] has been [redacted] for Resident #3. [redacted] will be done randomly on Resident #4.

Further review of the Care Plan for Resident #3 revealed the interventions were initiated on [redacted] day 1 of the survey. The interventions listed were: [redacted] will be [redacted] in resident's room; [redacted] will be [redacted] in the [redacted] Nursing staff will pick-up the [redacted] from the [redacted] clinic every [redacted]. [redacted] put on hold until further notice.

During an interview on 6/28/19 at 12:35 p.m., the DON reported Resident #3 returned from the hospital on [redacted], with a [redacted] which we believed was [redacted]. The ADON witnessed Resident #3 dropping the [redacted] into Resident #4's [redacted]. The police were called, they searched the room and found a [redacted] and a [redacted] which they confiscated. The bag of the [redacted] were given to the police. In addition, the DON reported new interventions were implemented after the incident. [redacted] in his/her room. [redacted] in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 689	Continued From page 22	F 689		

[redacted] and are monitored by the staff. Resident #3 is no longer [redacted]. The staff will go pick up the weekly [redacted].

3. According to the "Admission Record" (AR), Resident #4 was originally admitted to the facility on [redacted] and readmitted on [redacted] with diagnoses which included but were not limited to: [redacted]

According to the Minimum Data Set (MDs), an assessment tool dated [redacted] Resident #4 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the Resident was cognitively [redacted] The MDS also indicated Resident #4 required limited assistance for Activities of Daily Living (ADLs).

During an interview on 7/2/19 at 2:10 p.m., Resident #4 stated he/she is a [redacted] and was on [redacted] however, it was stopped prior to admission at this facility a year and a half ago. Resident #4 also stated: Resident #3 slipped a [redacted] into his/her bag because he/she knew they had stopped the [redacted] meds (medications) because of her association with Resident #3. In addition, Resident #4 reported there is [redacted] here in the facility and [redacted] activities by Resident #3, everyone in the facility knows about it, the nurses and the management, everyone. Resident #4 stated he/she knows for a fact that Resident #2 got Resident's #3's [redacted] and that he/she was [redacted] weeks ago and has a [redacted] pending.

Review of Resident #4's Care Plan (CP) showed the following under "Focus," [redacted] related

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 689	Continued From page 23 to [redacted] with a canceled date of [redacted] However, the CP did not address Resident #4's [redacted] and did not include any interventions related to safety. Review of the Policy titled "Incident and Accident" revealed the following under "Policy" It is the policy of this facility that accidents/incidents involving resident care will be investigated and documented on the Resident Incident Report (RIR), to enable the facility to evaluate care given to residents, to assist in prevention of incidents, and evaluate interventions implemented in the event of an incident. An "accident/incident" is any unusual event, occurrence, or happening which may or may not result in injury or illness to a resident. Review of the facility's policy titled [redacted]" with a creation date of 02/2014, and a "last reviewed" date of 02/2019, revealed the following under "Policy" "It is the policy of this facility to ensure that residents/patients who voice and/or display [redacted] actions receive services and interventions to help them manage feelings and maintain their psychosocial well-being." In addition, under "Procedure" section #9. Monitor resident/patient closely. Enlist assistance of other staff members to "look in" on resident/patient. Section #11. When the resident is no longer considered [redacted], the facility will develop a precautionary plan. This will ensure the provision of ongoing monitoring and assessment of the resident's mood status and interventions. N.J.A.C. 8:39-4.1 (a)(5)	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 689	Continued From page 24 This deficiency continues at a E level.	F 689		
F 741 SS=F	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: COMPLAINT: # NJ 125430, NJ 125438	F 741	1. Resident #2 is no longer at the facility.	8/30/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 741	Continued From page 25 Based on interviews, Medical Record (MR) review, and review of other pertinent facility documentation on 6/28/19 and 7/2/19, it was determined that the facility failed to adequately train the staff on [redacted] and interventions. In addition the facility failed to follow their Policy titled '[redacted] This deficient practice was evidenced by the following: 1. According to the "Admission Record" (AR), Resident #2 was originally admitted to the facility on [redacted], and readmitted on [redacted] with diagnoses which included but were not limited to: [redacted] due to Inhalation of Food and Vomit. According to the Minimum Data Set (MDs), an assessment tool dated [redacted], Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the Resident was cognitively [redacted]. The MDS also indicated Resident #2 required limited to extensive assistance with Activities of Daily Living (ADLs). Review of Resident #2's CP dated [redacted], showed the following: Under Focus: [redacted]. Under Goals: None were listed. Under Interventions: None were listed. Resident #2's CP showed no interventions for monitoring or supervising the resident for [redacted] or any interventions for the [redacted]. Review of Resident #2's "Progress Notes" written	F 741	2. Facility will review all residents with diagnosis of psychosocial disorder, post-traumatic stress disorder, history of [redacted] or [redacted], and history of trauma to identify and ensure that they have appropriate services provided. 3. all nurses were re-educated on the skills set to provide services to assure and ,maintain physical, mental, psychosocial well being of all residents. Including residents with diagnosis of psychosocial disorder, post-traumatic stress disorder, history of [redacted] or [redacted], and history of trauma. nursing staff were also re-educated on the updated policy of [redacted]. 4. Director of Nursing or Designee will ensure that all nursing staff have been re-educated, and all new hires educated in regards to any residents that have diagnosis of psychosocial disorder, post-traumatic stress disorder, history of [redacted], and history of trauma. And additionally trained on the updated policy of [redacted]. Training reports for employees and new hires will be reviewed monthly for 3 months and quarterly with findings to be reported at the QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 741	Continued From page 26 by the Nurse Practitioner (NP) dated [redacted] at 8:40 a.m., revealed the following: [redacted] thoughts without a plan: Pt (patient) cannot contract for safety. NP spoke to..[redacted] and ordered to send Pt to[redacted] for eval (evaluation). Nursing and nurse manager made aware. POC (Plan of Care) discussed with Patient and Nursing. Review of Resident #2's "PASRR Level [redacted] Determination Notification" dated [redacted], revealed the following: The above-named client has [redacted] treatment need that can be met in a Nursing Facility. The following recommendations are being made for the client: [redacted] consult upon admission to Nursing Facility. Routine follow up visits with Primary Care Physician and [redacted] Medication monitoring. Supportive Counseling. Routine Laboratory Testing. Formulate and implement a behavioral modification plan to address any behavioral disturbances. Provide education to client and family on [redacted] and medication. Develop a [redacted] Intervention/Safety Plan with the client. During an interview on 7/2/19 at 12:32 p.m., the Assistant Director of Nursing (ADON) stated, "The staff here are not in-serviced on [redacted] [redacted] or [redacted] just on safety." The ADON also stated "He/she (Resident #2) was being closely monitored for 72 hours after returning from the [redacted]. [redacted]) would be helpful here however, if they (residents) have [redacted] we send them out." Review of the facility's policy titled "Suicide	F 741		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 741	Continued From page 27 [redacted] with a "creation dated" of 02/2014, and a "last date reviewed" of 02/2019, revealed the following under Protocol: The facility designs and implements processes to provide physical and psychosocial served that adequately care for residents/patients admitted to the facility. To identify and prevent psychosocial dysfunction, the staff will not only observe the physical functioning of the resident/patient, they will also observe psychosocial functioning. This process allows the staff to detect early warning signs of major mood changes and/or possible [redacted] and obtain and provide appropriate interventions.	F 741		
F 835 SS=D	N.J.A.C. 8:39-11.27.1(a) Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: COMPLAINT: # NJ 125430, NJ 125438 Based on interviews, Medical Record (MR) review, and review of pertinent facility documentation on 6/28/19 and 7/2/19, it was determined that the facility's administration failed to ensure that the facility's policies and procedures were implemented including the Policy titled [redacted] for 1 of 4 sampled residents (Resident #2) who was	F 835	1. Resident #2 is no longer in the facility. 2. All residents with history of [redacted] or who were assessed to be at elevated risk of [redacted] or [redacted] (I.e. [redacted]) are at risk of being affected by the deficient practice. The administrator and DON reviewed and identified all residents with the above characteristics and ensured all aspects of	8/30/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 835	Continued From page 28 admitted on [redacted] a history of [redacted] and on [redacted] verbalized [redacted] and was sent to [redacted] for an evaluation and returned without a proper safety plan in place. This deficient practice was evidenced by the following: 1. According to the "Admission Record" (AR), Resident #2 was originally admitted to the facility on [redacted], and readmitted on [redacted] with diagnoses which included but were not limited to: [redacted]. According to the Minimum Data Set (MDs), an assessment tool dated [redacted], Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the Resident was cognitively [redacted]. The MDS also indicated Resident #2 required limited to extensive assistance with Activities of Daily Living (ADLs). Review of Resident #2's Care Plan (CP) with a "Created on" date of [redacted] revealed the following under "Focus" [redacted] related to on [sic] the process of [redacted] and no place to go home; history of [redacted] of an [redacted]." In addition under "Focus" was [redacted]" however there was no documentation under "Goal" or under "Interventions." The CP failed to address Resident #2's high risk for [redacted] to his/her past history [redacted] or put interventions in place related to the history of [redacted]	F 835	the appropriate policies are being meticulously followed. 3. The facility has replaced the administrator and the DON since the deficient practice was found. In addition, all nursing staff will be educated on [redacted] and [redacted] and will be educated on how to implement appropriate plan of care for identified Residents. Policy and Procedure for [redacted], and [redacted] will be reviewed, and updated to maintain resident safety and remain in compliance 4. Administrator and DON will audit all residents at risk for [redacted] on a weekly basis to ensure all policies and procedures are being followed for 3 months and then monthly for the next 3 months. Results of the audit will be will reviewed monthly by the VP of Clinical Services and VP of Operations, and at the facility quarterly QAPI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 835	Continued From page 29	F 835		

Review of the Facility's document titled "Admission Notification" dated of [redacted] at 6:30 p.m., and a document titled "New Admission Intake Form'" with a "Referral date" of [redacted] showed under "Past Medical History" history of [redacted] and under "Admit Dx" (diagnosis) [redacted]." In addition, review of the hospital document revealed under "Primary Diagnosis [redacted].

During an interview on 6/28/19 at 2:25 p.m., the Director of Nursing (DON) stated, Resident #2 only saw [redacted]) once during his/her stay at the Facility and did not see [redacted] after his/her visit to [redacted]. "I don't know why he/she was not seen again." In addition, the DON reported the [redacted] was in the facility on [redacted], for "[redacted] Monthly Review" with the team but did not see Resident #2 because the [redacted] was only there for the monthly review and she was not sure if the [redacted] was made aware of Resident #2's [redacted] visit on [redacted] for [redacted]

During a phone interview on 7/2/19 at 1:40 p.m., the [redacted] reported only seeing Resident #2 once and did not see him/her after the [redacted] visit on [redacted], but she was aware, Resident #2 went out to [redacted]. She stated "I didn't see him/her again because he/she just came back from the hospital. I don't know why I didn't see him/her on [redacted], when I was there for the monthly [redacted] review. I guess no one expressed concerns to me." In addition, the [redacted] stated "I feel the facility was equipped to handle residents with a history of [redacted]. It was an accidental [redacted] according to the hospital records. So yes, they were okay to handle

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	1302 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 835	Continued From page 30	F 835		

him/her."

Review of the progress notes for Resident #2 from [redacted] visit to [redacted] when Resident #2 [redacted] and died revealed the Social Worker (SW) met with Resident #2 five times. During that time period the SW charted one time regarding resident's behavior and [redacted] on [redacted], she reported "Resident is doing well with no reported behaviors of [redacted] at this time. Referral placed to [redacted] for evaluation. SS (Social services will continue to follow up prn (as needed).

During a phone interview on 7/2/19 at 10:25 a.m., with the Director of Social Services she reported she was aware of Resident #2's past history of [redacted] and she met with [redacted] 3 to 4 times a week. She also reported she was aware he/she was going through a divorce, had a history of [redacted], and was [redacted] at this time because of the [redacted]. She stated "I only chart or document what is important on the resident. There were no concerns, [redacted] was fine. I go by observations and he was fine. [redacted] did not give me any reason for concern."

During an interview on 7/2/19 at 12:32 p.m., the Assistant Director of Nursing (ADON) reported "The Care Plan is a document that we should be following. We failed to document properly, and we failed to update the Care Plan properly." In addition, the ADON agreed that during the monthly [redacted] on [redacted], the team should have discussed Resident's #2 [redacted] visit on [redacted] and the [redacted] should have seen the Resident at that time.

According to the Facility's Policy titled [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315187	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOORHEES CARE & REHABILITATION CENTER, THE	**1302 LAUREL OAK ROAD VOORHEES, NJ 08043**

(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 835	Continued From page 31 [redacted] dated 2/2014 and 2/2019, revealed the following: under "Policy" "It is the policy of this facility to ensure that residents/patients who voice and/or display [redacted] actions receive services and interventions to help them manage feelings and maintain their psychosocial well-being." 9. Monitor resident/patient closely. Enlist assistance of other staff members to "look in" on resident/patient. 11. When the resident is no longer considered acutely suicidal, the facility will develop a precautionary plan. This will ensure the provision of ongoing monitoring and assessment of the resident's mood status and interventions. N.J.A.C. 8:39-13.4 (3)(b)	F 835		