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 01/14/2020

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 128934, NJ 127874, NJ 127896 CENSUS: 169 SAMPLE SIZE: 5	F 000		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Complaint # NJ 127896 Based on interviews, review of the medical record (MR) and other facility documentation, it was determined that facility staff failed to perform skin assessments/skin checks, obtain treatment orders and implement timely interventions to prevent the development of a [redacted] [redacted] for 1 of 5 sampled residents (Resident #2) who was at risk for the development of a [redacted] In addition, a facility staff member, Licensed Practical Nurse (LPN) #1 administered	F 686	1. Resident #2 is no longer in the facility. 2. All residents are at risk to be affected by the deficient practices related to skin and [redacted] 3. All residents will have their Treat Administration records audited to ensure all skin checks are signed. A skin sweep of all residents will be completed to ensure there are no skin issues without treatments, any (previously documented)	2/25/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/11/2020

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.

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 01/14/2020

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 686	Continued From page 1 treatments to Resident #2's skin impairment without a physician order (PO). According to a facility investigation, a facility staff member, Certified Nurse's Aide (CNA) #1 noted in (date unknown) and reported it to LPN #1. LPN #1 instructed the CNA to apply a after incontinent care. In (date unknown), CNA #1 reported to the same LPN that the sacral area had developed an . According to CNA #1, LPN #1 initiated treatment "whenever she was working," however, there was no documentation in the MR of a skin impairment, or any treatment administered to a until when Resident #2 was assessed with which required This deficient practice was evidenced by the following; Reference: defined by the The updated staging system includes the following definitions: : A is localized to the or related to a medical or other The injury can present as or an and may be . The injury occurs as a result of intense and/or prolonged in with . The tolerance of for r may also be affected by and of the . Injury:	F 686	areas have appropriate treatments ordered by the physician, and that appropriate prevention interventions are implemented. All resident care plans will be audited to ensure prevention intervention and treatment plans (where indicated) are in place. All licensed nurses will be re-educated regarding skin checks, prevention of skin breakdown, skin breakdown reporting, treatment and documentation. As well as obtaining Physicians orders for all skin care needs. 4. The DON or designee will audit 4 residents x 4 weeks, then 4 residents x 2 months. The audit will consist of post skin check observation of residents skin, review of the Treatment record to review for correct skin check signature/documentation, treatment order if needed, physicians order if needed, prevention interventions implemented and appropriate care plans in place. All findings will be reported during QAPI x 90days.	

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 01/14/2020

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 686	Continued From page 2 skin skin with a of , which may appear differently in . Presence of b may precede visual changes. do not include discoloration; these may indicate injury. Injury: of skin with , and may also present as an . is not visible and are not visible. tissue, and are not present. These injuries commonly result from adverse This not be used to describe related skin injury or Injury: in which) is visible in the and) are often present. and/or may be visible. The depth of varies by can develop . and may occur.	F 686		

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 01/14/2020

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 686	Continued From page 3 and/or are not exposed. If obscures the extent of this is an Injury. Injury: with exposed or directly and/or visible. and/or often occur. Depth varies by anatomical location. If the extent of this is an and 1. According to the facility Admission Record, Resident #2 was admitted in . Diagnoses included but were not limited to; with . An annual Minimum Data Set (MDS), an assessment tool, dated revealed the resident had a Brief Interview for Mental Status (BIMS) score which indicated moderately impaired cognition, needed assistance with all activities of daily living (ADLs) and was incontinent of bowel and bladder. The MDS indicated the resident was at risk for , however, did not have a . A significant change MDS, dated , indicated the resident had cognition, was incontinent of bowel and bladder, needed assistance with all ADLs and had a	F 686		

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 01/14/2020

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 686	Continued From page 4 Review of a Care Plan (CP), initiated [redacted] included that the resident was at risk for skin breakdown related to (r/t) [redacted] and incontinence. Interventions included to assess for changes in skin condition each shift, complete skin risk assessment as per facility policy, monitor skin care daily, provide protective/preventative skin care and turn and position every 2 hours. There was no indication on the CP that the resident had a [redacted] prior to [redacted] The CP was updated on [redacted] with the addition of a [redacted] Interventions included to administer treatment as ordered, consult with wound specialist, encourage adequate consumption of meals/fluids, blood work to include [redacted], [redacted] [redacted] [redacted] on chair when out of bed, re-enforce prompt incontinent care and off-loading of pressure points and limit out of bed (OOB) to 2 hours (hrs.) /day. Review of a Braden Scale (used for Predicting Pressure Ulcer Risk) dated [redacted] revealed a score of [redacted] which indicated the resident was "Low Risk." Review of Physician Orders (POs) revealed the following; Weekly skin check on shower days on Saturday during 7-3 shift. If skin intact-No changes. If with Skin Opening/Trauma -follow protocol. (initiated [redacted]. Preventative skin Care every shift with ADLs. (initiated [redacted] Review of the 2/2019 through 4/6/2019 Treatment Administration Records (TARs) confirmed the	F 686		

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 01/14/2020

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 686	Continued From page 5 POs for "weekly skin checks" on the 7-3 shift. For 9 of 10 opportunities from 2/1/2019 through 4/6/2019, "weekly skin checks" were signed/initialed as completed by LPN #2 and #3 on the following dates; LPN #2-2/2, 2/16, 3/16, 3/30/2019 and LPN #3-2/9, 2/23, 3/9, 3/23, 4/6/2019. There was no indication in the TAR that the resident had a skin impairment or a [redacted] treatment/dressing from 2/1 through 4/7/2019. On 3/2/2019, the TAR was signed/initialed by LPN #2 and noted to see the progress notes (PNs). A PN, dated [redacted] at 10:41 am, by LPN #2 revealed the resident refused a shower, and a bed bath was performed. During an interview with the surveyor on 1/8/2020 at 11:00 am, Unit Manager (UM) #1 confirmed that the PO for preventative skin care to be done daily with ADLs was, perineal care completed by CNAs. She stated that the licensed nurses would "ask the CNA" if it was done and then check it off on the TAR. She also stated that CNAs were to report any change in skin condition immediately to the nurse. Review of nursing, nutrition and physician PNs, dated 2/1/2019 through 4/7/2019, did not reveal any indication of a sacral wound or the administration of a wound treatment. Review of a PN, dated 4/8/2019 at 3:24 pm, and a "Change in Condition" PN, dated 4/8/2019 at 2:42 pm, by LPN #2 revealed; "Noticed [redacted] [redacted] [redacted]] with unit manger during round." The [redacted] was measured at [redacted] [redacted] A physician order (PO) was obtained and a treatment performed.	F 686		

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 01/14/2020

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 686 Continued From page 6 F 686

A PN, dated at 3:16 pm, by the Nurse Practitioner (NP) #1 revealed; "Nurse called and reports patient has ... [Resident #2] does have . bed is clean. Positive for] drainage. No malodor. Consult with care specialist. Off-loading and local care with and . Reviewed VS [vital signs] and weight. ...has 3 % weight lost over past month. ." The NP documented the of the as approximately .

During a telephone interview with the surveyor on 1/14/2020 at 10:26 am, NP #1 confirmed she was called to assess the on . NP #1 stated she did not measure the with a ruler but measured it with her trained eye. She confirmed that she observed in the , but she did not measure the of the at that time because she did not have access to anything to measure with.

During an interview with the current Director of Nursing (DON) #1 on 1/7/2020 at 12:00 pm and 1/8/2020 at 9:00 am, the surveyor requested the Incident Report (IR) and investigation r/t the documented on . DON #1 stated that although she was able to retrieve an IR from the electric MR, she was unable to locate a full investigation with statements from staff. The DON stated that she thought the facility initiated and conducted a QAPI (Quality Assurance and Performance Improvement) plan because a nurse was administering treatments to a wound without a PO, although she was not the DON at that time. The DON did provide an IR and "Investigation Report" r/t 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 01/14/2020

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 686	Continued From page 7	F 686		

Review of a facility IR, dated [redacted], completed by LPN #2 revealed that the [redacted] was found with the Unit Manager (UM) during rounds and was noted at a [redacted] [redacted] and treatment was performed. The physician and responsible party (RP) were notified.

Review of the MR did not reveal any documentation in the assessments, PNs or skin checks prior to [redacted] which indicated any skin impairment for Resident #2.

Review of the "Investigation Report" completed by the previous DON #2 and dated [redacted] included the following;
On 4/8/2019 the [redacted] floor UM was informed of an opened [redacted] on Resident #2 and the resident was assessed with a [redacted] [redacted] with [redacted] ...." Interviews were conducted with staff directly involved with Resident #2's care.

The "Investigation Report" included a summary of interviews of "staff who were directly involved with [Resident #2's] care...";

a.) 3-11 shift CNA #1: "[CNA #1] claimed that about 2 months ago he noted [redacted] in the [redacted] of [Resident #2]. He informed the 3-11 cart nurse [LPN #1] who instructed him to put skin barrier cream [after] every incontinence care. He further stated that about a month ago, the [redacted] area started to open. He informed again [LPN #1] who told him she'll inform the physician. Per [CNA #1], [LPN #1] initiated treatment and had been treating the [redacted] whenever she was working. [CNA #1] said that

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 01/14/2020

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 686	Continued From page 8 he firmly believed that [LPN #1] informed the unit manager and the nursing management." b.) 7-3 shift CNA #2, who was the regularly assigned CNA for Resident #2, "...claimed that she never noticed the [redacted] in [Resident #2's] [redacted] not until a week ago. She stated that she thought nursing management had been informed since whenever she gives nursing care to [Resident #2] she sees a dressing on the [redacted] Hence she did not mention anything to the UM." c.) 7-3 shift LPN #2: "[LPN #2] stated that he was not aware that [Resident #2] had a [redacted] since no CNA called his attention. [LPN #2], who was supposed to [have] assessed resident's skin during shower days acknowledged that he was not doing it consistently." d.) 7-3/3-11 shifts, part-time LPN #3: "[LPN #3] claimed that a CNA ask [asked] her to do a treatment for [Resident #2]. Upon looking at the doctor's orders, there was none written. She immediately checked the [redacted] and confirmed the presence of the [redacted]. She then informed the Unit Manager which prompted the investigation." Additionally, the investigation included that the resident was alert but [redacted]l, required total assist with ADLs, was incontinent of bowel and bladder, had [redacted] [redacted]) and used a wheelchair (w/c). For the past 3 months [redacted] general condition started to decline and [redacted] "continues to be a [redacted]" and on [redacted] [redacted] Due to the overall physical decline alone with limited physical mobility and incontinence	F 686		

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 01/14/2020

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 686	Continued From page 9 Resident #2 was predisposed to develop a pressure injury. The resident "is currently on [redacted] liquids which puts her at risk for [redacted] which is very detrimental in the maintenance of good skin integrity. [redacted] [redacted] was noted to be [redacted] which is markedly low. Due to the multiple co-morbidities ...it has been concluded by the administrative team that [Resident #2's] [redacted] injury is considered unavoidable." There was no statement/interview documented for 3-11 shift LPN #1, who CNA #1 had initially reported the [redacted] skin in [redacted] and skin opening in [redacted]. During a telephone interview with the surveyor on 1/8/2019 at 11:40, the previous DON #2 confirmed that she initiated an investigation after the [redacted] was noted on [redacted]. DON #2 stated that LPN #1 did not follow the facility protocol when the skin impairment was initially reported in [redacted]. DON #2 confirmed that according to CNA #1 the area had been reddened approximetely 2 months prior. Then, one month prior the [redacted] had opened and the nurse was applying an ointment. DON #2 stated facility protocol was not followed; an IR was not initiated/completed, the physician and nursing management were not notified, nurses were not checking resident's skin when signing for skin assessments and CNAs were not reporting changes in skin conditions. DON #2 stated she did not know when and what LPN #1 had been treating the [redacted] with during that time. She confirmed that she did a complete investigation, including statements but left all of it at the facility when she left.	F 686		

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 01/14/2020

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 686	Continued From page 10	F 686		

Review of facility "Daily Attendance Report" and "Time Card Report" for LPN #1, from 2/1 through 4/7/2019, revealed that LPN #1 worked the 3-11 shift on the [redacted] for 19 of 28 days in 2/2019, 22 of 31 days in 3/2019 and 4 of 7 days from 4/1 through 4/7/2019.

Review of an "Employee Discipline Report" for 3-11 LPN #1, dated [redacted], included that the "Date of Incident" was [redacted] for failure to follow instructions and unsatisfactory job performance. "...employee failed to do the following upon identification of a newly developed [redacted] on [Resident #2]; a) failed to do an incident report and full assessment and documentation of the [redacted], b.) failed to inform the attending physician and responsible party, c.) failed to inform the nursing management/administration. Above employee was administering [redacted] treatment without a physicians order." LPN #1 was terminated.

LPN #1 was unavailable for interview.

Review of an "Employee Discipline Report" r/t [redacted] incident for 7-3 shift LPN #2, dated [redacted] included; "Above employee failed to do a skin check during shower days of resident [#2]. This deficient practice lead to the failure of early identification of a [redacted] injury that was developing on resident [#2]. This failure also lead to a delay for an aggressive management of the [redacted]." LPN #2 was suspended for 2 days and in-serviced on skin protocol, notification of the physician and Responsible Party (RP).

During a telephone interview with the surveyor on 1/10/2020 at 2:20 pm, LPN #2 confirmed that he was not aware the resident was receiving a

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 01/14/2020

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 686	Continued From page 11	F 686		

[redacted] treatment or had any skin breakdown from 2/1 through 4/7/2019. The surveyor asked if he noted a [redacted] when he completed his skin checks on 2/2, 2/16, 3/16 and 3/30/2019 and LPN #2 stated he could not recall. LPN #2 stated that CNAs never reported to him any skin issue for Resident #2 and "we depend on [them] for feedback." LPN #2 also stated that if a resident refused a skin check, he would do a "limited" skin check by just looking at exposed areas, which did not included the [redacted] region but would still sign/initial the TAR to indicate it was completed. He stated he would document in the PNs that it was a "limited" assessment. LPN #2 confirmed that he never looked at Resident #2's [redacted] during a skin check.

Review of an "Employee Discipline Report" for 7-3/3-11 shift LPN #3, dated [redacted] included that LPN #3 "...failed to do a skin check during shower as ordered by the physician. This deficient practice lead to a failure of early identification of a [redacted] on [Resident #2]. This also led to delayed aggressive management of...the [redacted] " LPN #3 was suspended for one day.

During a telephone interview with the surveyor on 1/9/2019 at 2:55 pm, LPN #3 confirmed that she was suspended because of not doing a proper skin check, however, she did not remember anything about the skin checks she signed/initialed as completed on [redacted] or anything prior for Resident #2.

Review of an "Employee Discipline Report," dated [redacted] r/t the [redacted] incident included that CNA #2 "...failed to render a through nursing care during her shifts hence missing to identify 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 01/14/2020

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 686	Continued From page 12	F 686		

presence of a [redacted] injury on one of her "regularly-assigned" residents." Expected Outcome: "...When rendering care, one is expected to thoroughly wash and clean all body parts and immediately report to the nurse for any abnormal skin findings." CNA #2 was suspended for 2 days.

CNA #2 was unavailable for interview by the surveyor.

Review of the [redacted] Consult, dated [redacted], revealed that it was the initial exam and the wound was assessed at a [redacted] [redacted] Injury" to the [redacted] with exposed [redacted]e, moderate amount of [redacted], a well-defined [redacted] [redacted]. The [redacted] was [redacted] and measured [redacted] by [redacted] after [redacted]. A low air loss mattress was noted in place. [redacted] was [redacted] which is [redacted] and inconsistent with adequate [redacted]. A repeat [redacted] was ordered in 2 weeks. A [redacted] was recommended while in bed and [redacted] [redacted] [redacted] saturated gauze twice daily and cover with border gauze twice daily.

Review of a facility policy dated 12/2018 and titled; [redacted] Management Program" included but was not limited to the following; "To provide a standardized action in the management of, and to aid in the prevention or the development of pressure ulcers. Procedure: ...Skin observations will be completed daily by care givers during the provision of morning care. Noted changes will be reported at that time to the District Nurse, who will examine the area and

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 01/14/2020

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 686	Continued From page 13 document pertinent findings. A team that consists of Nurse and DON or ADON will make wound rounds weekly. [redacted] will be monitored and accurate descriptions will be recorded in the wound report...to note the degree of progress and response to treatment...If the patient has a [redacted] [redacted]), and/;or develops a [redacted], the [redacted] Care Protocol will be implemented by the Nurse. the IDT [Interdisciplinary Team] will discuss the evaluation and a specific personalized plan of care will be developed...The Nurse will initiate treatment according to the facility's [redacted] Care Protocol. These interventions will be placed in front of the ...TAR and on the plan of care and will be implemented by all caregivers.[redacted] will be assessed weekly by a wound specialist with the Nurse according to the facility's policy for wound Assessment documentation...." Review of facility policy titled; [redacted] Management Program" and dated [redacted] included but was not limited to; "To provide a standardized action in the management of, and to aid in the prevention of the development of [redacted]. Procedure: ...Skin observations will be completed daily by caregivers during the provision of morning care. Noted changes will be reported at that time to the licensed nurse, who will examine the area and document pertinent findings...The Licensed Nurse will initiate treatment according to the facility's [redacted] Care Protocol. These interventions will be placed in front of the Treatment Administration Record (TAR) and on the plan of care and will be implemented by all care givers. [redacted] will be assessed weekly by a licensed nurse according to the facility's policy for [redacted] Assessment Documentation."	F 686		

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 01/14/2020

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 686	Continued From page 14	F 686		

Review of a facility policy titled; "[redacted] [redacted] Documentation" dated 12/2019, included but was not limited to; "The purpose of this guideline is to provide a consistent process for accurate and complete [redacted] treatment documentation. The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented...Treatment Documentation Guidelines: Type of [redacted] ([redacted]...), [redacted]..Description..., Current treatment...Progress towards healing, effectiveness of current interventions...Modifications of interventions...notifications to physician and/or responsible party regarding [redacted] or treatment changes...Frequency of [redacted] Documentation: Routinely..PRN [as needed] with any resident change in condition or change in [redacted] status."

NJAC: 8:39-27.1 (a) (b)

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		2/25/20

§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.

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 01/14/2020

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 842	Continued From page 15	F 842		

§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained 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

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 01/14/2020

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 842	Continued From page 16 legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint # NJ 128934 Based on observation, interview and review of medical records, and other facility documentation, it was determined that the facility failed to follow their own policy titled, "Clinical Narrative Documentation" by not documenting a resident discharge and return to facility for 1 of 5 sampled residents (Resident # 3). This deficient practice was evidenced by the following: According to the Admission Record, Resident #3 was admitted to the facility on [redacted] with diagnosis that included but were not limited to: [redacted] A review of the Minimum Data Set (MDS), an assessment tool, dated [redacted] indicated the resident had [redacted] cognitive impairment and required extensive staff assistance for Activities	F 842	1. Resident #3 returned to facility. Nurse will put in late entry of progress note for the Resident #3. 2. All residents are at risk by the deficient practice. Audit will be done to review discharges going back 30 days to ensure residents who were discharged had a progress note in place. 3. Policy and procedure on discharge and documentation was reviewed and updated. All licensed nurses re-educated on the policy and procedure of documentation and discharge process. 4. DON or Designee will review 6 discharged residents' progress notes weekly x 4 weeks than monthly x 2 months to ensure documentation of teaching and admission and discharge note took place. All findings will be reported during QAPI x 90days.	

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 01/14/2020

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 842	Continued From page 17 of Daily Living (ADLs). Review of the Care Plan dated [redacted] revealed the resident required [redacted], [redacted] and [redacted] is. Interventions included to change [redacted] y dressing daily and keep patent and intact at all times. Additionally, the CP included a focus for d/c as the resident was admitted as a short-term placement and would return to the community when appropriate. The goal was to d/c home appropriately per desired goal. Review of a Progress Note (PN), dated [redacted] at 7:54 pm, by Licensed Practical Nurse (LPN) #4 revealed Resident #3 was scheduled to be discharged (d/c'd) from the facility to a [redacted]. LPN #4 documented that Resident #3 was d/c'd to a [redacted] at 6:20 PM, however, the nurse stroke out the note by putting a line across the PN sentence. Review of a PN, approximately 3 hours later, dated [redacted] at 10:59 pm by LPN #4 revealed that the resident was in bed resting with [redacted]), denies [redacted] or [redacted]. During an interview with the surveyor on 1/8/2019 at 12:30 pm, LPN #4 confirmed that the resident was d/c'd to the [redacted] on [redacted]. LPN #4 stated a [redacted] manager came to pick up the resident and the resident left via a wheelchair (w/c). However, approximately one hour later, the resident was back because the [redacted] could not manage care for the [redacted]. LPN #4 stated she did not consider the resident d/c'd because the resident was still in the electronic-MR when [redacted] returned.	F 842		

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 01/14/2020

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 842	Continued From page 18	F 842		

She confirmed that she did not document why and when the resident returned or the status of the resident upon arrival.

During a telephone interview with the surveyor on 1/10/2019 at 3:37 pm, 3-11 shift Supervisor, Registered Nurse (RN) #1 stated she d/c'd Resident #3 to 2[redacted] representatives. She confirmed that she provided teaching on [redacted] care and provided the supplies to the [redacted] representatives. RN #1 confirmed that she did not document the d/c or the d/c teaching in the E-MR. In addition, RN #1 stated the resident returned to the facility approximately one hour later because the [redacted] was unable to care for a resident who needed dressing changes. RN #1 confirmed that d/c, d/c teaching should be documented in the MR.

During an interview with the surveyor on 1/14/2020 at 2:00 pm, the Director of Nursing (DON) stated that LPN #4 did document the d/c but crossed it out when the resident returned to the facility. The DON confirmed that the nurse should have written a PN when the resident returned.

A review of the facility policy titled "Clinical Narrative Documentation" dated 5/2019 and revised 12/2019 included but was not limited to; "It is the policy of this facility to provide clinical narrative documentation as it occurs using factual and objective information. Narrative documentation will be charted either in the electronic or paper medical record. Actual time of the entry will be documented referencing time of specific occurrences, if documented after the fact. Clinical narrative documentation will be

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 01/14/2020

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 842	Continued From page 19 provided for a minimum of 72 hours, including but not limited to, the following circumstances: ...New admission/readmission. A single narrative entry will occur for the following episodes: ...Discharge... NJAC: 8:39-35.2 (d) (16)	F 842		