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 08/27/2020

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 #s NJ00132647, NJ00134475, NJ00136051, NJ00136269, NJ00136896 Census: 153 Sample Size: 9 THE FACILITY IS NOT IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES, BASED ON THIS COMPLAINT VISIT.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint #-NJ 00136051 Based on interview, review of medical records and other pertinent facility documentation it was determined that the facility failed to follow professional standards of practice and in accordance with facility policy for a.) documenting a fall in the medical record and b.) obtaining a physician's order for treatment to a skin injury. This occurred for 1 of 9 residents reviewed (Resident #1) for incident and accidents and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title	F 658	1.Resident #1 is no longer resides in the facility. 2. All residents were at risk for having an incident that didn't have a progress note in the medical record or have a treatment order in place for a skin impairment. Facility has reviewed and looked backed 30 days of incident reports to ensure progress note of incidents were captured and for any skin impairment treatment was obtained for residents. 3. DON/ Designee reviewed policy and	9/18/20

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

Electronically Signed | 09/15/2020

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F 658	Continued From page 1 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing a medical regimen as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." According to Resident #1's Admission Record (AD) dated [redacted], Resident #1 was admitted to the facility with the diagnoses of [redacted] The Significant Change Minimum Data Set (MDS) dated [redacted] indicated that Resident #1 was cognitively intact, had no behaviors and was able to ambulate with supervision. The	F 658	procedure for incident and accident and re-educated all nursing staff on documentation of incidents under medical records and obtaining a treatment for skin impairment. 4. DON/Designee will review audit 5 incidents reports weekly to ensure documentation is in medical record and for skin impairment treatment is in place x 90 days and report all findings in QAPI monthly x3.	

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F 658	Continued From page 2	F 658		

MDS also indicated that the resident had a fall.

The surveyor reviewed a facility Post Incident and Accident Report (PIAR) dated [redacted] at 04:00 AM, which indicated that Resident #1 reported that he/she fell to a Licensed Practical Nurse (LPN) in the early morning hours. The resident told the LPN that there were no witnesses to the fall and that he/she did not report the fall to any other staff member. The resident reported to the LPN that he/she was coming out of the bathroom and he/she fell on the left side and hurt his/her [redacted]. The PIAR indicated that a full assessment was performed, and a [redacted] was noted on Resident #1's [redacted] and that the Nurse Practitioner and family were notified about the incident.

The Physician/Practitioner Progress Notes (PPN) dated [redacted] at 14:03 PM, the Nurse Practitioner (NP) indicated that Resident #1 had fallen, and a [redacted] was noted on the [redacted] with other exposed areas intact. There was no documentation in the PPN notes that the NP ordered a treatment for the [redacted] of Resident #1's [redacted]

On 8/25/2020 at 1:00 PM, the surveyor attempted to telephone interview the NP and the NP was not available for interview.

The surveyor could not find documentation in the Nursing Progress Notes (NPN) from the LPN that Resident #1 had fallen, was assessed for having a [redacted] or that a treatment was performed to the [redacted].

The surveyor reviewed the Physician Order Recap dated [redacted] and there was

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F 658	Continued From page 3 no treatment order for [redacted] of the [redacted] The surveyor reviewed the Treatment Administration Record (TAR) dated [redacted] and there were no physician orders for treatments to the [redacted]. On 8/25/2020 at 12:40 PM, the surveyor interviewed the LPN who stated that she was not sure why she didn't document the fall for Resident #1 on [redacted] in the NPN. She stated that she just completed an incident report. LPN stated that Resident #1 had a history of falling and then getting up by [redacted]. The resident reported to her that he/she injured his/her [redacted] and the LPN observed a [redacted] on the [redacted]. The LPN stated that she notified the NP about the fall after it was reported to her. In a subsequent interview dated 8/25/2020 at 3:00 PM, the LPN stated that she could not remember if she obtained a treatment order for Resident #1's [redacted]. The LPN added that she thought she put [redacted] on the [redacted] and covered it with a border gauze but admitted that she did not document the treatment or get a treatment order from the physician. On 8/25/2020 at 1:30 PM, the surveyor interviewed the LPN Charge Nurse who confirmed that the LPN should have documented the details of Resident #1's fall of [redacted] in the NPN according to the facility policy. The LPN Charge Nurse also stated that it was expected that the LPN should have obtained a treatment order and documented that a treatment was performed to Resident #1's [redacted] in the TAR.	F 658		

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On 8/25/2020 at 2:15 PM, the surveyor interviewed the Director of Nursing (DON) who confirmed that the LPN should have documented the fall dated [redacted] in the nursing progress notes in Resident #1's medical record.
The nursing progress note should have included the date, time, injuries, treatments provided, interventions and who was notified about the fall.
The DON revealed that the PIAR was an internal record and not part of the medical record and that this was why an NPN should be written after an accident or incident.
The DON also confirmed that the LPN should have received a treatment order for Resident #1's [redacted], performed the treatment and then documented that the treatment was completed in the TAR.

On 8/27/2020 at 2:35 PM, the DON and Administrator were interviewed and the DON stated that since the NP also documented that Resident #1 had a [redacted] as a result of the fall, then he should have also ordered a treatment.
The Administrator confirmed that the LPN should have followed the facility policy and documented the fall of [redacted] in the medical records and should have obtained a treatment order for the [redacted] that was assesed on the resident's [redacted]

The facility policy dated 02/2020 and titled, "Incident and Accident" indicated that a Licensed nurse/supervisor documents the occurrence on the 24-hour report and in the Progress Notes of resident/patient medical record.
Documentation in the Progress Notes contains

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F 658	Continued From page 5 only clear objective facts, details of the event, such as: -Date -Time -Where accident/incident occurred -Who first noticed accident/incident -Where involved resident/patient was located (i..., sitting on the floor, lying in bed, ect.) -Resident condition-objective findings of physical examination (includes description of resident's vital signs and physical characteristics apparent as a result of the accident/incident) -Treatments provided and or assistance given. -Appropriate interventions put in place immediately. -Names of persons notified (i.e., Physician, family) -Document response of the family/significant other at the time of the notification. N.J.A.C 8:39-27.1 (a) (b)	F 658		