STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PHOENIX CENTER FOR REHABILITATION AND PEDIATRICS	**1433 RINGWOOD AVE HASKELL, NJ 07420**

(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 REVISED STATEMENT OF DEFICIENCY COMPLAINT #: NJ127126 CENSUS: 180 SAMPLE SIZE: 4 Based on observation, interviews and review of the medical records, and other facility documentation on 8/12/19, 8/13/19 and 8/15/19, it was determined that the facility failed to implement interventions to protect 1 of 4 sampled residents (Resident #2) from [redacted] by a contracted staff member. After a prior allegation of [redacted] in [redacted] a contracted housekeeping staff member was directed not to be alone in an occupied Resident's room. The lack of staff education of the plan and a lack of monitoring of the staff member following the [redacted] allegation, afforded the contracted housekeeping staff member an opportunity to enter a resident's room without question. The contracted housekeeping staff member was observed by another staff member on [redacted] [redacted] abusing a [redacted] resident (Resident #2) in the resident's room. After the [redacted] incident, staff interview revealed that housekeeping staff were to notify a nurse prior to entering an occupied resident room. On the day of survey 8/15/19, staff observations noted housekeeping staff were entering and leaving occupied resident rooms without prior notification to a nurse. This deficient practice was identified for 1 of 4 residents reviewed for [redacted] abuse (Resident #2). The facility Administrator and the Director of Nursing (DON) were made aware of the immediate	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/23/2019

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.

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F 000	Continued From page 1 jeopardy situation on 8/15/19 at 3:40 PM. The removal plan was provided by the facility on 8/15/19 at 6:05 PM. The IJ was lifted on 8/16/19 when the removal plan was implemented.	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. §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 #: NJ127126 REVISED STATEMENT OF DEFICIENCY Based on observation, interviews and review of the medical records (MRs), and other facility documentation on 8/12/19, 8/13/19 and 8/15/19, it was determined that the facility failed to implement interventions to protect 1 of 4 sampled residents (Resident #2) from [redacted] abuse by a contracted staff member. After a prior allegation of [redacted] abuse in [redacted] by sampled Resident #3, a contracted housekeeping staff member was directed not to be alone in an occupied Resident's	F 600	THIS PLAN OF CORRECTION IS BEING SUBMITTED IN CONFORMANCE WITH APPLICABLE REGULATIONS AND SHALL NOT BE CONSIDERED AN ADMISSION OF ANY FACT OR VIOLATION ALLEGED IN THE SURVEY REPORT. THE PROVIDER RESERVES IT'S LEGAL RIGHTS TO CONTEST ANY OF ALL ALLEGATIONS CONTAINED IN THE SURVEY REPORT. IJ removal plan was provided by the facility to DOH on 8/15/19 at 6:05 pm. See below for POC accepted by DOH:	8/16/19

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F 600	Continued From page 2 room. The lack of staff education of the plan and a lack of monitoring of the staff member following the [redacted] allegation, afforded the contracted housekeeping staff member (Housekeeper #1), an opportunity to enter a resident's room without question. Housekeeper #1 was observed by another staff member on [redacted] abusing a [redacted] resident (Resident #2) in the resident's room. After the [redacted] incident, staff interview revealed that housekeeping staff were to notify a nurse prior to entering an occupied resident room. On the day of survey 8/15/19, staff observations noted housekeeping staff were entering and leaving occupied resident rooms without prior notification to a nurse. This deficient practice was identified for 1 of 4 residents reviewed for [redacted] abuse (Resident #2). The facility Administrator and the Director of Nursing (DON) were made aware of the immediate jeopardy situation on 8/15/19 at 3:40 PM. The removal plan was provided by the facility on 8/15/19 at 6:05 PM. The IJ was lifted on 8/16/19 when the removal plan was implemented. 1. According to the "Admission Record," Resident #2 was admitted to the facility in [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 had [redacted] impairment. The MDS also indicated Resident #2 required total staff assistance for Activities of Daily Living (ADLs).	F 600	1. The Housekeeper who committed the alleged [redacted] abuse was immediately terminated by the facility. The housekeeper as per Police report was arrested on [redacted] and charged with aggravated criminal [redacted] contact and remanded to the county jail. The resident was sent to the hospital for evaluation and returned to the facility the same day. The resident will be provided emotional and psychological support by the Social Worker three times per week and the [redacted] will visit resident two times per week. These visits will be conducted for one month and then weekly for three months and will be reevaluated for any symptom of emotional and psychosocial trauma if further visits are needed. Social Worker and [redacted] will document visits on the progress notes. There is no identified post traumatic emotional and psychological trauma at this time. 2. All male housekeepers will be educated by the Housekeeping Director starting 8/15/19 and completed on 8/16/2019 not to enter a resident's room when a female resident is present in the room. If a female resident is bedbound or unable to leave the room, a female housekeeper will be assigned to do housekeeping duties in the room. Housekeeping Director/Designee/Nursing Supervisor will make daily rounds on all shifts to ensure that a male housekeeper is not entering a resident's room when a female resident is in the room. 3. All staff will be educated starting	

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F 600	Continued From page 3 A care plan (CP), initiated in [redacted], included that Resident #2 was dependent on staff for activity involvement and social interaction due to [redacted] and physical limitations. The resident had [redacted] related to (r/t) [redacted] and [redacted]. Interventions included but were not limited to; be aware and sensitive of the resident's feelings and responses and monitor for signs and symptoms of discomfort. A facility Reportable Event Record (AAS-45) was sent to the New Jersey Department of Health (NJ DOH) by the Administrator on [redacted]. The AAS-45 indicated that at approximately 6:55 AM on [redacted] a Certified Nursing Assistant (CNA) #1 observed a contracted [redacted] housekeeper (Housekeeper #1) enter Resident #2's room and not exit. CNA #1 went to investigate and upon drawing back the privacy curtain observed Housekeeper #1 leaning over Resident #2 with [redacted] on Resident #2's [redacted]. Resident #2 was in bed in her room at the time of the incident. The nursing supervisor was informed and the Police were notified. Housekeeper #1 exited the unit via an elevator and exited the facility. An investigation was initiated and Resident #2 was sent to the Hospital Emergency Room (ER) on [redacted] for an evaluation. Resident #2 was [redacted] and not capable of being interviewed. During an entrance conference with the surveyors on 8/12/2019 at 1:45 PM, the Administrator confirmed the information in the AAS-45. The Administrator also confirmed that Housekeeper #1 never returned to the facility after the incident and the incident was followed up by the local	F 600	8/15/2019 by the Staff Development/designee and will be ongoing to ensure that all staff are aware that male housekeepers are not allowed to be alone in a resident's room where a female resident is in the room. All staff were educated and completed on 8/16/2019. 4. Housekeeping Director/designee/Nursing Supervisor will conduct a random daily observation of male housekeepers on all shifts for four weeks to ensure that male housekeepers will not be alone in resident's room when a female resident is present, after 4 weeks, a weekly audit will be conducted for 3 months or until 100% compliance is reached. The audit will be conducted on the F600 Audit form, the auditor will fill out the form and report findings to the Administrator. Outcome of the audit will be reported quarterly to the QA Committee until 100% compliance is reached. The QA Committee will provide review and oversight for further evaluation and recommendations.	

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F 600	Continued From page 4 police department. The surveyor conducted an interview with Certified Nursing Assistant (CNA #1) on 8/12/19 at 2:48 PM and on 8/13/19 at 11:38 AM. CNA #1 stated that on [redacted] at approximately 7:00 AM, she observed Housekeeper #1 exit the elevator and walked straight into Resident #2's room. CNA #1 stated she became suspicious because Housekeeper #1 did not have any housekeeping equipment i.e.machine, garbage bags or a garbage can with him. CNA #1 walked down the hallway (approximately 113 feet), entered Resident #2's room, moved the privacy curtain from around the bed and observed Housekeeper #1 leaning over Resident #2 with [redacted] over Resident #2's [redacted]. She further stated that she began screaming for someone to call the police. Housekeeper #1 covered the resident's [redacted] with a sheet and exited the room. CNA #1 also stated, once before, not sure of the date, Housekeeper #1 was buffing the floor in that room while Resident #2 was in bed and later came out of the room. CNA #1 further stated that on another previous occasion, approximately 3 weeks to 1 month ago, she and CNA #2 saw Housekeeper #1 enter Resident #2's room. "When we got there, he [Housekeeper #1] was coming out of the room. When we asked him what he was doing in that room, he did not answer. He was there about 4 to 5 minutes." CNA #1 stated she did not think much of it at the time but she thought that maybe he was checking on a privacy curtain. She stated she did not report it to a nursing supervisor because he was a housekeeper. During an interview with the surveyor on 8/13/19 at 11:45 AM, CNA #2 stated that she had	F 600		

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F 600	Continued From page 5 previously seen Housekeeper #1 go into Resident #2's room in the morning before 7 AM. CNA #2 said she was not sure of the date, but that it was approximately 3 weeks to 1 month ago. CNA #2 stated that on that day, it did not make sense for Housekeeper #1 to be on the floor at that time. She and another CNA (CNA #1) walked down toward Resident #2's room. She stated that as they arrived at the door, Housekeeper #1 walked out of the room. "We did not report because he is a housekeeper and he is assigned at times to clean rooms and empty the garbage." CNA #2 stated that it was a "little suspicious," but because he had been in and out of resident rooms buffing the floors, cleaning the floors from room to room and taking out the garbage, she did not initially think to report. During an interview with the surveyor on day 2 of survey, 8/13/2019 at 12:27 PM, the Administrator stated that on a previous occasion in [redacted] [redacted] another sampled resident, (Resident #3) alleged that Housekeeper #1 touched the resident's [redacted] The Administrator stated that after that incident in [redacted], all staff were made aware that Housekeeper #1 was not allowed to be in a room alone, if a resident was in the room. After the incident on [redacted] the Administrator indicated, "Staff were in-serviced that any staff, visitors, residents, anything suspicious, staff should report immediately." The Administrator was unable to provide documented facility wide in-services from the [redacted] incident. The facility provided an AAS-45 from [redacted] which indicated that sampled resident (Resident #3) who resided on the [redacted], alleged that Housekeeper #1 put his hand down Resident #3's shirt and touched [redacted]. The facility	F 600		

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F 600	Continued From page 6 conducted an investigation and notified the Department of Health, family and police. Housekeeper #1 was suspended during the investigation and was returned to work on [redacted]. The facility was unable to substantiate the allegation. A review of the police report, dated [redacted] indicated the Administrator was informed that the police did not have enough to sign a complaint for [redacted] assault. The police recommended that Housekeeper #1 would no longer be in Resident #3's presence and that Housekeeper #1 needed to be told to stop touching the residents. Review of [redacted] AAS-45 included the facility plan after the incident. The plan for "Follow-up," dated [redacted] included that Housekeeper #1 returned to work on [redacted] and would no longer be assigned to the [redacted]. Additionally, "A new directive for housekeeping staff was issued: No floor cleaning or buffing if resident is in bed. If resident unable to leave bed and room, the cleaning will be postponed if possible. If it is not possible to postpone, an additional staff member will be in room for the duration of cleaning." During an interview with the surveyor on day 2 of survey, 8/13/2019 at 12:27 PM, the Administrator stated that after the [redacted] incident, the Housekeeping Director was also aware that if housekeeping staff have to go into a resident's room, they are to inform the nursing staff, that they are going in a room. During an interview with the Director of Housekeeping (DH) on 8/12/19 at 3:58 PM, DH stated that on [redacted], Housekeeper #1 left the facility and was terminated. DH further stated that	F 600		

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F 600	Continued From page 7 there was a previous allegation in [REDACTED] that Housekeeper #1 touched a [REDACTED] resident (Resident #3's) [REDACTED] During an interview with the surveyors on 8/13/19 at 4:02 PM, the DH stated he was aware of the previous incident with Housekeeper #1 in [REDACTED]. He stated that Housekeeper #1 was in-serviced in [REDACTED], that he could not go to residents' rooms. The DH stated that Housekeeper #1 was also instructed not to do light housekeeping services, because he was not to be in any resident's room alone. As per DH, Housekeeper #1 did not abide by the restrictions. DH also stated that he did not in-service any other staff regarding Housekeeper #1 at that time. "There was no system, no in-services of nursing to alert them that he was not allowed in resident rooms by himself." The DH stated he did not in-service nursing or housekeeping because the allegation in [REDACTED] was found not valid. During an additional interview with the surveyors on 8/15/19 at 10:04 AM, the DH stated, "In [REDACTED] I think we took him (Housekeeper #1) off the floor and then allowed him back because the allegations were false." DH further stated that Housekeeper #1 was instructed to stay off the [REDACTED] for a while; approximately 1 month. "Staff were not in-serviced that he (Housekeeper #1), was not allowed on the [REDACTED]." The DH stated that Housekeeper #1 was allowed to work as a light housekeeper, if they were short staffed. "He was always a heavy housekeeper and there was no reason for him to go into residents rooms unless he was buffing the floor. If we were short, he would do both. After the incident on the [REDACTED], he could only do heavy housekeeping duties, however on the other floors	F 600		

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he was allowed to perform light and heavy housekeeper duties. I would monitor him to see what he was doing. Monitor means daily rounds, but not monitoring him per say. Just check to see what they are doing and if they missed a procedure. He should not have been, where he should not have been."

On 8/15/19 the surveyor requested the job descriptions for light housekeeping and heavy housekeeping. The surveyor also requested verification of the housekeeping Bi-weekly Schedules and description of each assignment. The Director of Housekeeping stated, a heavy housekeeper was responsible to pull trash from trash rooms, dust, mop and wet mop corridors, vacuum and spot clean the carpets and buff the floors. A light housekeeper was responsible to clean resident rooms, dining rooms, nursing station, break room and nursing bathroom.

The surveyor reviewed the Housekeeping Bi-Weekly Schedule from [redacted] to [redacted]. The surveyor observed, Housekeeper #1 had worked on all 4 units performing light and heavy housekeeping. A review of the Bi-weekly schedule for the period beginning [redacted] to period ending on [redacted] indicated that on [redacted], Housekeeper #1 was assigned to perform heavy housekeeper responsibilities on the [redacted]. However, Housekeeper #1 was found on the [redacted] in Resident #2's room on [redacted]

During an interview with Staff Educator/ Registered Nurse (RN #2) on 8/13/19 at 2:09 PM, RN #2 confirmed that on Housekeeper #1's return to work on [redacted], she in-serviced Housekeeper #1 that he was not to be alone in resident rooms with residents during

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housekeeping procedures. "This was for his self preservation." RN #2 stated, she did not find any in-services nor did she remember giving in-services to any other staff that Housekeeper #1 should not have been alone in a room with a resident. She stated that only Housekeeper #1 was in-serviced.

During an interview with the Administrator on 8/15/19 at 11:50 AM, the Administrator stated, "Yes I agree in hindsight, the staff should have been in-serviced in [redacted] and that may have prevented this incident on [redacted]

Review of a facility "In-service" sheet, dated [redacted], signed by RN #2 and Housekeeper #1 indicated the following: In the "Objective/Material Presented" section: "[Housekeeper #1] will understand the categories of abuse, abuse prevention and reporting requirements." The in-service indicated, but was not limited to: "Reviewed not being alone in room with residents during housekeeping procedures."

During an interview with the Assistant Director of Nursing (ADON) on 8/15/19 at 1:00 PM, the ADON stated that male housekeepers had to report to the nurse before entering any resident rooms. "This is still ongoing. It was initiated on [redacted]." The ADON stated the male housekeepers were aware before the incident on [redacted] that they had to report to nursing prior to entering resident rooms. "I believe they were in-serviced not to go into female rooms, if the female resident was in the room. This is for any housekeeping procedures, even picking up the trash. After [redacted] everybody was in-serviced that housekeeping staff are not allowed in female rooms, where females are in bed. The nurses

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reinforce and keep reminding them [housekeeping staff]. The nurse should stop them and say, 'hold on, this is a female room and you have to inform me.' The nurse should monitor and everybody's responsibility is to see and watch housekeeping and inform the supervisor of any male that enters the room and what the response was." The facility was unable to provide any documentation of an in-service for all staff.

During an interview with the surveyor on 8/13/19 at 12:27 PM, the Administrator confirmed that Housekeeper #1 was not allowed to be in the room alone if a resident is in the room.

During interviews with the surveyor on 8/12/19 and 8/13/19 unit 2 CNA #1 and CNA #2 revealed that they were in-serviced on reporting abuse, but they were never in-serviced that Housekeeper #1 could not go into resident rooms alone.

During an interview with CNA #3 on 8/13/19 at 11:00 AM, CNA #3 who works on the [redacted] unit stated that she was never in-serviced that Housekeeper #1 was not allowed in female rooms.

During an interview with CNA #4 on 8/13/19 at 10:27 PM, CNA #4 who works on the [redacted] unit stated that if a resident is bed bound, housekeeping do enter the resident's rooms alone and empty the garbage, they put in paper towels and mop the floor. "No one ever alerted me that [Housekeeper #1] was not allowed in a female room, if the resident was in the room."

During an interview with CNA #5 on 8/15/19 at 1:32 PM, CNA #6 who works on the [redacted] stated she did not get any in-services regarding

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housekeeping not being alone in the resident's room.

During an interview with the surveyor on 8/15/19 at 8:47 AM, the Staff Member #6 who works on the [REDACTED] stated no one watches what time housekeeping goes into resident rooms. "No one pays any mind. It is an honor system. When housekeeping come on the floor, they tell us 'I am going to be on this side or that side.' I have never been in-serviced that porters are not to be in any resident's room. Porters and housekeepers fall under housekeeping."

During an interview with [REDACTED] Licensed Practical Nurse (LPN #1) on 8/15/19 at 1:44 PM, LPN #1 stated she did not receive any in-services about housekeeping. LPN #1 also stated that no one from housekeeping asked her to go with them when they pick up the garbage from the residents rooms or to watch them when they enter the room.

During an interview with [REDACTED] LPN #2 on 8/15/19 at 1:54 PM, LPN #2 stated he was not aware that housekeeping was supposed to inform nursing when they go to the room, if the resident was in bed.

During an interview with [REDACTED] LPN #3 on 8/13/19 at 9:58 AM, LPN #3 stated, "When housekeepers come to the floor, they tell us what side they are assigned to. No formal monitoring of housekeepers. The housekeepers should not be in the room when a patient is in the room. Only pick up trash, but out in 2 seconds."

During an interview with the surveyor on 8/13/19 at 3:14 PM, Social Worker #1 (SW) stated that

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she was not aware that Housekeeper #1 was not allowed to be in any rooms alone. She further stated that she did not receive any in-services regarding Housekeeper #1.

During an interview with the surveyor on 8/13/19 at 3:16 PM, SW #2 stated that she did not know about the incident from [redacted]. She further stated the she has no knowledge that Housekeeper #1 was not allowed to be in residents room alone.

The Housekeeping Director provided the surveyor an in-service document, dated [redacted] which was given to the housekeepers at the facility on the same date. A review of the facility in-service was titled; "In-service For: Notifying Nusing [SIC: Nursing] Location Of Cleaning. In-service Meeting Sign-In Sheet," dated [redacted] indicated signatures which were included but not limited to: Housekeeper #2 and Housekeeper #3.

On 8/15/19 at 8:20 AM, the surveyor observed [redacted] Housekeeper #2 enter 4 female rooms and 3 male rooms alone. The female residents were in bed and the housekeeper did not inform nursing that he was entering the resident rooms. The surveyor observed the housekeeper collect trash from the resident's bedside trash receptacle and from the bathroom trash receptacle.

During an interview with the 3rd floor Housekeeper (#2) on 8/15/19 at 8:39 AM, the Housekeeper stated, "I knock on the door and say 'housekeeping'. If resident is in the room, I can go in myself. I let the nurses know I am in the room." During the interview the surveyor informed Housekeeper #2 that the surveyor did not observe Housekeeper #2 inform the nurse when

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he entered resident rooms while the residents were in bed. Housekeeper #2 became quiet and did not respond.

On 8/15/19 at 8:25 AM the surveyor observed the [redacted] Housekeeper #3 enter 9 occupied resident rooms. The housekeeper did not inform nursing regarding him entering the resident rooms. The surveyor observed the housekeeper collect trash from the resident's bedside trash receptacle and from the bathroom trash receptacle.

During a telephone interview with the 4th floor Housekeeper (#3) on 8/27/19 at 10:01 AM, Housekeeper #3 stated that after the incident in [redacted], housekeeping was allowed to go inside female rooms to clean. He stated he was not in-serviced at that time, however, he was in-serviced after 8/15/19, that male housekeepers were not allowed to go inside female rooms.

There was no indication that after the [redacted] [redacted] incident with Housekeeper #1, that the facilty implemented a monitoring plan to ensure Housekeeper #1 did not go into any residents room alone. The facility also failed to in-service other staff in the facility to inform them that Housekeeper #1 was not to enter resident rooms. Additionally, although documentation indicated housekeeping were in-serviced on [redacted] to not go into resident rooms alone, nursing staff were not made aware and during observation during survey on 8/15/2019, housekeeping staff were observed entering occupied resident rooms alone without making nursing aware.

A review of the facility policy entitled "Nursing Abuse, Neglect & Mistreatment - Staff To

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Resident," dated 01/2012 indicated the following:

Policy:
The facility will endeavor to ensure that residents are free from verbal, sexual physical and mental abuse...
Definition:
Abuse - is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental,and psychological well-being. This presumes that instances of abuse even to those residents in a coma, cause physical harm, physical pain or mental anguish.

Sexual Abuse includes, but is not limited to sexual harassment, sexual coercion, or sexual assault.

Staff Training:
Reinforcing that the facility staff has the legal responsibility to report any activity which they know, or have reasonable cause to suspect is abuse, neglect, or exploitation.
Appropriate interventions to deal with aggressive and/or catastrophic reactions of residents.

Prevention:
In order to identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur, the facility will analyze:
The deployment of staff on each shift in sufficient numbers to meet the needs of the residents, and assume that the staff has knowledge of the individual residents' care needs.

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Staff will be educated during training to tell their supervisors or the administrator when they identify inappropriate staff behaviors such as using derogatory language, rough handling, ignoring residents while giving care, etc.

Identification: Unannounced rounds will be made by Department Heads and house supervisors each shift, 7 days per week, checking remote areas such as stairwells, behind closets, doors and pulled curtains.

Investigation:
The Administrator will oversee all necessary corrective actions depending on the result of the investigation.

Protect resident During Investigation:
Prevent further potential abuse while investigations are in progress by alerting staff to closely monitor the alleged victim, and suspend suspected staff member(s) pending completion of the investigation.

Reporting:
a 1. The Abuse Coordinator or designee, as directed by the Administrator will report such incidents immediately by telephone to:
Department of Health and Senior Services.
b. If there is an incident of abuse of any nature, the Nurse in charge will complete a Resident Accident and Incident Report (SM 6), which will be reviewed by the Administrator and the Director of Nursing.
c. Resident who are the suspected object of abuse, neglect or mistreatment should be physically examined immediately to determine whether the resident has suffered symptoms of physical harm.

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F 600	Continued From page 16 e. The facility will thoroughly investigate and document each alleged violation and will prevent further potential abuse while the investigation is in progress, under the direction of the Abuse Coordinator. NJAC 8:39 - 4.1 (a) (5) NJAC 8:39 - 14.2 (a) (c)	F 600		

New Jersey Department of Health

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	061628	A. BUILDING: ______ B. WING ______	C **08/15/2019**

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S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing	S1680		10/7/19

(b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a) above) on the basis of:

1. Total number of residents multiplied by 2.5 hours/day; plus

2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day:

Wound care
0.75 hour/day
Nasogastric tube feedings and/or gastrostomy 1.00 hour/day
Oxygen therapy
0.75 hour/day
Tracheostomy
1.25 hours/day
Intravenous therapy
1.50 hours/day
Use of respirator
1.25 hours/day
Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day

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S1680	Continued From page 1 This REQUIREMENT is not met as evidenced by: Complaint #: NJ127126 Based on review of the Nurse Staffing Reports for the week of 8/4/19, it was determined that the facility failed to provide at least minimum staffing levels for 1 of 7 days. The required staffing hours and actual staffing hours are as follows: For the week of 8/4/19 Required Staffing Hours: 647.50 Date Actual Staffing Hours Difference 8/4/19 624 -23.50 During an interview with the surveyor on 8/15/19 at 11:50 AM, the Administrator confirmed that staffing was short. The Administrator stated that there were no care issues reported. for 8/4/19.	S1680	1. There were no care issues reported on 8/4/19. 2. DON reviewed the last 30 days of nursing staffing reports. Staffing needs were met by the facility. Recruitment efforts are in place to assist the facility in recruiting Nurses and CNAs including referral bonus, proposal for a new salary structure for CNAs and a recruitment agency was hired to assist with the efforts. DON and nursing management is also reviewing staff attendance records to ensure that excessive absences are addressed and disciplinary warning are issued as needed. 3. The Administrator inserviced the DON/Nursing Management/Staffing Coordinators on 9/19/19 regarding the requirements of S1680 to ensure that staffing needs are reviewed daily and addressed as needed to meet the nursing staffing requirements. 4. The DON/designee will review daily staffing reports everyday for 3 months and then weekly for 6 months or until 100% compliance is reached to ensure that nursing staffing needs are met as per	

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S1680	Continued From page 2	S1680	regulation. The outcome of the audit will be reported by the DON monthly to the Administrator and quarterly to the QA Committee for further discussion and recommendation.	