STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315513	A. BUILDING ______ B. WING ______	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWERBACK REHABILITATION, ROUTE 73	**113 SOUTH ROUTE 73 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 STANDARD SURVEY CENSUS: 115 SAMPLE SIZE: 29 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	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: Based on interview, record review and review of other facility documentation, it was determined that the facility failed to accurately transcribe a physician ordered medication in accordance with nursing standards of clinical practice. This deficient practice was identified for Resident #171, 1 of 29 residents reviewed for medications and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through	F 658	1. Patient # 171 physician ordered medication failed to be transcribed in accordance with the physician order scheduled date. The following was completed as corrective action for patient found to have been affected by the alleged practice. Patient #171 initial physician ordered medication date was changed to match the scheduled physician order date. The identified, patient�s physician ordered medications was reviewed for accuracy and there were no other orders transcribed against the scheduled physician order date. A random audit of ten patients'� physician ordered medications were reviewed and there were no inaccuracies with	8/15/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 07/30/2019

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
	315513	A. BUILDING ______ B. WING ______	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWERBACK REHABILITATION, ROUTE 73	**113 SOUTH ROUTE 73 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 658	Continued From page 1 such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens 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 states: "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." During the initial tour of the facility on 7/2/19 at 9:53 AM, Resident #171 stated the facility administered incorrect doses of a medication. Resident #171 further stated that he/she informed the facility of the medication discrepancies and requested a copy of the physician orders for review. The resident also said that there was concerns about the medication discrepancies and wanted to be discharged early. According to the Admission Record, Resident #171 was admitted to the facility on [redacted] with diagnoses that included [redacted]. A review of the [redacted] evaluation also indicated the resident had a past medical history of [redacted] Review of the Social History & Initial Assessment	F 658	medication transcription found. Physician services and nursing staff were in-serviced on the importance of completing a double check system with transcription of orders by reviewing and assuring the date of the physician order is accurate and consistent with the scheduled physician order date. An in-service was conducted with the licensed nursing staff for inputting physician orders with focus on transcription start dates. 2. In order to identify other residents having the potential to be affected by the same alleged deficient practice, the following will be completed: A random audit of 15 patient□s physician ordered medications were reviewed for transcription inaccuracy with initial order against scheduled order. There were no new findings. The RN Clinical Director will audit 5 to 10 random patient□s physician ordered medications twice a week to monitor for inaccuracy in transcription date. All findings will be reported to the CNE. 3. The process for medication transcription was reviewed. In addition to second licensed staff reviewing physician transcription orders, a new additional step was initiated for the evening nurse supervisor to review physician orders with focus on scheduled transcription date. An in-service training session was conducted with licensed staff for inputting physician orders with focus on transcription start dates. The Clinical Director will monitor this process and conduct audits twice weekly until compliance achieved 100%.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315513	A. BUILDING ______ B. WING ______	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWERBACK REHABILITATION, ROUTE 73	**113 SOUTH ROUTE 73 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 658	Continued From page 2 v2, an assessment tool dated [REDACTED], indicated that the Resident #171 was [REDACTED] Review of the "Order Summary Report" (OSR) reflected the following physician's order: [REDACTED] [REDACTED] [REDACTED] Review of Resident #171's June 2019 EMAR revealed the following physician orders: The order dated 6/26/19 for [REDACTED] The order dated 6/27/19 for [REDACTED]	F 658	All findings will be reported to the CNE for follow up as necessary. 4. The Clinical Director or designee on a monthly basis will randomly select six patients□ physician medications orders and monitor for accuracy of transcription order. A report will be submitted Center Nurse Executive and reviewed by the care delivery team at the monthly QI meeting until 100% compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315513	A. BUILDING ______ B. WING ______	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWERBACK REHABILITATION, ROUTE 73	113 SOUTH ROUTE 73 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 658	Continued From page 3 [redacted] for 1 week and then dose increases and is ordered for 1 week [sic] with the administration times of 9:00 AM and 9:00 PM. The medication start date was ordered for 6/27/19 at 9:00 PM. The medication was documented as administered on 6/27/19 at 9:00 PM; 6/28/19 at 9:00 AM and 9:00 PM; 6/29/19 at 9:00 AM and 9:00 PM; and 6/30/19 at 9:00 AM and 9:00 PM. The order dated 6/26/19 for [redacted] after a week with the administration times of 9:00 AM and 5:00 PM. The medication start date was ordered for 6/26/19 at 17:00 (5:00 PM). The medication was documented as administered on 6/26/19 at 5:00 PM and 6/27/19 at 9:00 AM. The order dated 6/26/19 for [redacted] for 1 week for 1 week [sic] with the administration times of 9:00 AM and 5:00 PM. The medication start date was ordered for 6/26/19 at 5:00 PM. The medication was documented as administered on 6/26/19 at 5:00 PM. As indicated above, the EMAR revealed that on 6/26/19, Resident #171 was administered two doses of [redacted] at 5:00 PM, and one dose of [redacted] at 9:00 PM. The EMAR further revealed that on 6/27/19, Resident #171 was administered one dose of [redacted] and one dose of [redacted] at 9:00 AM, and one dose of [redacted] at 9:00 PM. A review of Resident #171's progress note written by the nurse practitioner on 6/26/19, revealed that	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315513	A. BUILDING ______ B. WING ______	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWERBACK REHABILITATION, ROUTE 73	**113 SOUTH ROUTE 73 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 658	Continued From page 4 was to be administered two times a day for one week and then increased. During an interview on 7/9/19 at 10:00 AM, the Director of Nursing (DON) stated the initial physician order dated 6/26/19 was for two times a day for one week, then increase it to two times a day for an additional week. The DON further stated that it was a transcription error and that the physician had written two orders on the same date. The DON confirmed that Resident #171 received two and one on 6/26/19 and two on 6/27/19. The DON stated the were started too early. The DON confirmed that Resident #171 was supposed to only receive two times a day on both 6/26/19 and 6/27/19. The DON further stated there was no adverse reaction and the physician was informed of the transcription error. The facility was unable to provide a policy for physician's orders transcription. NJAC 8:39-11.2 (b)	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced	F 695		8/10/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315513	A. BUILDING ______ B. WING ______	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWERBACK REHABILITATION, ROUTE 73	113 SOUTH ROUTE 73 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 695	Continued From page 5 by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to administer oxygen in accordance with the physician's orders. This deficient practice was identified for 1 of 6 residents reviewed for respiratory care (Resident #317) and was evidenced by the following: The surveyor observed Resident #317 receiving at a at the following dates and times: 7/1/19 at 11:32 AM; 7/2/19 at 10:22 AM; 7/5/19 at 9:36 AM; and 7/5/19 at 9:59 AM. Review of the active physician's orders for Resident #317 revealed an order, dated 6/22/19, for According to the July 2019 Medication Administration Record (EMAR), Resident #317 received at the prescribed rate from 7/1/19 through 7/5/19. During an interview on 7/5/19 at 10:05 AM, the Registered Nurse (RN) stated that Resident #317 was receiving due to a recent episode of and confirmed that the resident currently had an order to administer On 7/5/19 at 10:23 AM, the surveyor accompanied by the RN, in the presence of the resident and the Certified Nursing Assistant	F 695	1. Patient # 317 failed to receive ordered in accordance with the physician order. The following was completed as corrective action for patient found to have been affected by the alleged practice: The identified patient were reviewed with results of greater than on . The identified patient was per physician order. Nursing staff was re-in serviced on importance of maintaining the as well as checking the on meter to match the physician order. 2. In order to identify other residents having the potential to be affected by the same alleged deficient practice, the following will be completed: A random audit was completed of six patients on to check the against the physician order. There were no new findings. The RN Charge nurse will audit 2 to 3 patients weekly to check flow meter rate against the physician order and report findings to CNE. 3. The process of monitoring against active physician order was reviewed for accuracy of percentage rate. The RN Clinical Director will audit for accuracy of flow rate and nursing documentation of flow rate weekly x4, until achieved compliance. All findings will be reported to the CNE 4. The Clinical Director or designee on a monthly basis will randomly select ten patients' physicians orders and monitor for accuracy of against	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315513	A. BUILDING ______ B. WING ______	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWERBACK REHABILITATION, ROUTE 73	**113 SOUTH ROUTE 73 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 695	Continued From page 6 (CNA), observed that the [redacted] was being administered to the resident [redacted]. The RN acknowledged that the [redacted] and reconfirmed that the resident currently had an order for [redacted]. She also stated that they were in the process of [redacted]. During an interview on 7/5/19 at 10:29 AM, the RN provided the surveyor with an order dated 6/23/19, which indicated to [redacted] and [redacted] The RN stated that orders for [redacted] and the resident is monitored for [redacted] at rest and during activity for response. The RN stated that she did not know how the quantity of [redacted] to be changed was determined, but it was usually decided by the Nurse Practitioner (NP). During an interview on 7/5/19 at 10:32 AM, the NP, who was familiar with Resident #317, stated the resident was initially on [redacted] and subsequently decreased to a [redacted]. The NP further stated that the resident was also being monitored for changes in [redacted]. The NP and RN provided an order dated 7/5/19 and timed at 10:26 AM, to [redacted]. The NP confirmed that prior to the referenced order, the resident should have received [redacted], as per the order that was in effect. The NP could not offer any explanation as to why the resident was receiving [redacted], before the new order dated 7/5/19.	F 695	physician order. The CNE will submit a report to the monthly QI meetings until 100% compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315513	A. BUILDING ______ B. WING ______	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWERBACK REHABILITATION, ROUTE 73	113 SOUTH ROUTE 73 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 695	Continued From page 7 Review of a facility policy titled, [redacted]," revised 2/1/19, indicated for staff to document the [redacted] An additional policy titled, "OPS410 Taking Medication and Treatment Orders," dated revised 3/20/17, indicated that the purpose of the policy was to ensure all medication and treatment orders are received from a credentialed practitioner before implementing. During an interview on 7/5/19 at 9:50 AM, the Director of Nursing, in the presence of the Licensed Nursing Home Administrator and survey team, stated that Resident #317 had an order to wean oxygen and also acknowledged that the specific order that decreased the [redacted] was not implemented until the surveyor brought it to the attention of the facility staff. NJAC 8:39-27.1(a)	F 695		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		8/10/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315513	A. BUILDING ______ B. WING ______	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWERBACK REHABILITATION, ROUTE 73	**113 SOUTH ROUTE 73 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 880	Continued From page 8	F 880		

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315513	A. BUILDING ______ B. WING ______	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWERBACK REHABILITATION, ROUTE 73	113 SOUTH ROUTE 73 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 880	Continued From page 9 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and review of other facility documentation, it was determined that the facility failed to ensure 1.) staff perform hand hygiene in accordance with the facility policy for 2 of 2 nurses observed during medication pass, and 2.) respiratory equipment was stored in an appropriate way to prevent the spread of infection for 1 of 6 residents reviewed for respiratory care (Resident #320). This deficient practice was evidenced by the following: 1. On 7/3/19 at 9:06 AM, the surveyors observed Licensed Practical Nurse (LPN #1) administer medication to the first resident during the medication pass. Upon completion of the medication pass, LPN #1 washed her hands with soap and water for 12 seconds, outside the stream of water. On 7/3/19 at 10:27 AM, the surveyors observed another nurse, LPN #2, administer medication to a second resident. Upon completion of the medication pass, LPN #2 washed her hands with	F 880	1. Two staff members failed to perform proper hand hygiene in accordance with the facility policy. [redacted] for patient #320 was not stored in a plastic bag while not in use according to storage policy. The following was completed as corrective action for patient found to have been affected by the alleged practice: The two staff members were both re-inserviced on proper hand hygiene procedure with return demonstration. The [redacted] for patient #320 was discarded. New [redacted] was provided and stored properly in a plastic bag. Staff were re-inserviced on [redacted] [redacted] policy with focus on storage of [redacted] in plastic bag while not in use. Staff inservices on proper hand washing technique with return demonstration will be completed in nursing and other departments. Staff were inserviced on importance of proper storage of [redacted] when not in use; placing tubing in a plastic bag when not in use.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315513	A. BUILDING ______ B. WING ______	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWERBACK REHABILITATION, ROUTE 73	**113 SOUTH ROUTE 73 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 880	Continued From page 10 soap and water for 5 seconds, under the stream of water. There was an additional medication required for this resident that was not available in the medication cart. LPN #2 obtained the required medication from the back-up supply and then began walking back towards the room of the resident who required it. At 10:40 AM, LPN #2 was called into the room of another resident to provide assistance. After doing so, the surveyors observed LPN #2 wash her hands with soap and water for 8 seconds, outside of the stream of water, and then returned to the room of the second resident, to administer the remaining medication. During an interview on 7/3/19 at 10:44 AM, LPN #2 stated that the facility was committed to infection control. She further stated that hands were to be washed for a minimum of 15 seconds, that once lathering occurred, rinsing could be performed a few seconds later, and that lathering and rinsing could not occur at the same time. When asked about the shorter times observed by the surveyors, LPN #2 could not offer any reasons for why this occurred and stated she tried to remain consistent. She stated that she tried to time her hand washing by singing the "Happy Birthday" song to herself. During an interview regarding the facility's hand washing policy on 7/3/19 at 10:56 AM, the Nurse Practice Educator stated that hand washing was supposed to occur for 20 seconds, using soap and water. A review of a facility policy titled, "IC203 Hand Hygiene," dated revised 11/28/17, indicated that hands were to be wet with warm water, soap was to be applied, and hands were to be rubbed	F 880	2. In order to identify other residents having the potential to be affected by the same alleged deficient practice, the following will be completed: An audit was completed to observe random staff for proper hand washing technique in nursing and other departments. An audit was completed of patients on [redacted] with focus on storage of [redacted] in plastic bag while not in use. There were no new findings. Nurse Clinical Director will randomly audit staff for proper handwashing technique 2 to 3x a week and report findings to CNE. The Clinical Director will audit [redacted] for proper storage 2 to 3x a week and report findings to CNE. 3. The process for monitoring storage of [redacted] was reviewed and revised to add a step for unit clerk to check [redacted] 2x week for proper storage of [redacted] in bag. The process for monitoring proper hand washing technique was reviewed. The NPE or designee will randomly conduct staff handwashing competency weekly x 4 until 100%. All findings will be reported to the CNE. 4. The Nurse Practice Educator or designee on a monthly basis will randomly audit storage of [redacted] and handwashing technique for accuracy in compliance; report will be submitted to QI meetings monthly until 100% compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315513	A. BUILDING ______ B. WING ______	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWERBACK REHABILITATION, ROUTE 73	**113 SOUTH ROUTE 73 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 880	Continued From page 11 vigorously outside the stream of water for 20 seconds, covering all surfaces of the hands and fingers. 2. During a tour of the [redacted] on 7/2/19 at 9:43 AM, the surveyor observed Resident #320 lying in bed with [redacted] The surveyor observed Resident #320's wheelchair with an [redacted] hanging on the handle of the resident's wheelchair. The [redacted] was not in use and not stored in a plastic bag. The surveyor made the same observation on 7/3/19 at 9:54 AM. According to the Admission Record, Resident #320 was admitted to the facility on [redacted] with diagnoses that included but not limited to: [redacted] A review of the electronic Medical Record (EMR) revealed a physician's order, with an initiated date of 6/30/19, for [redacted] continuously every day shift. The EMR also reflected an additional physician's order, with an initiated date of 6/30/19, for [redacted] continuously every night shift. During an interview on 7/3/19 at 10:14 AM, LPN #3 confirmed that the [redacted], when not in use, should be stored in a clear plastic bag. The surveyor and LPN #3 entered Resident #320's room and observed the [redacted] hanging on the handle of the resident's	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315513	A. BUILDING ______ B. WING ______	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWERBACK REHABILITATION, ROUTE 73	**113 SOUTH ROUTE 73 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 880	Continued From page 12 wheelchair, not in use, and not in a clear plastic bag. During an interview on 7/3/19 at 10:33 AM, the Unit Manager stated that [redacted] when not in use is to be stored in a clear plastic patient belonging bag and labeled with the resident's name. During an interview on 7/9/19 at 10:49 AM, the Director of Nursing confirmed that [redacted] should be stored in a plastic bag when not in use. A review of a facility policy titled, [redacted] [redacted]" dated revised 2/1/19, revealed that the [redacted] is to be dated and stored in a treatment bag when not in use. NJAC 8:39-19.4(a)(k)	F 880		