PRINTED: 07/13/2022 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  SOUTHGATE HEALTH CARE CTR  SOUTH GATE HEALTH CARE CTR  TAG  INTITUDE COMPLIANT SOUTH SOUTH SOUTH GATE HEALTH CARE CARE CARE CARE CARE CARE CARE CARE		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE	SURVEY PLETED
MANE OF PROVIDER OR SUPPLIER  SOUTHGATE HEALTH CARE CTR  (MI) D  (MI)			315237	B. WING				
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  FOOD  INITIAL COMMENTS  Complaint#: NJ144342  Census: 98  Sample Size: 3  THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REGUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITY SINCT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.  F 609  Reporting of Alleged Violations Seb. 10 or mistreatment, the facility must:  \$483.12(c) (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is moved, if the events that cause the allegation involve abuse and on or result in serious bodily injury, to the administrator of the facility and do to ther officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.  \$483.12(c)(4) Report the results of all investigations to the administrator or his or her				449	S PENNSVILLE-AUBURN ROAD	1 00.	21/2021	
Complaint#: NJ144342  Census: 98  Sample Size: 3  THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.  Reporting of Alleged Violations SS=D  OFR(s): 483.12(c)(1)(4)  \$483.12(c) (1) response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  \$483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation on on the or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.  §483.12(c)(4) Report the results of all investigations to the administrator or his or her	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION
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THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.  F 609 Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.  §483.12(c)(4) Report the results of all investigations to the administrator or his or her		Census: 98						
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neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.  §483.12(c)(4) Report the results of all investigations to the administrator or his or her				F 6	609			6/29/21
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		involving abuse, neg mistreatment, includi source and misappro are reported immedia hours after the allega that cause the allega serious bodily injury, the events that cause abuse and do not rest the administrator of tofficials (including to adult protective servi for jurisdiction in long accordance with Stat procedures.	lect, exploitation or ng injuries of unknown opriation of resident property, ately, but not later than 2 ation is made, if the events tion involve abuse or result in or not later than 24 hours if the allegation do not involve sult in serious bodily injury, to the facility and to other the State Survey Agency and ces where state law provides geterm care facilities) in the law through established					
	ADODATORY	-				TITLE		(Ve) DATE

Electronically Signed 07/05/2021

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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315237	B. WING		C 06/21/2021		
NAME OF PROVIDER OR SUPPLIER  SOUTHGATE HEALTH CARE CTR				STREET ADDRESS, CITY, STATE, ZIP CODE 449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 08069	1 00/21/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION		
F 609	accordance with Stat Survey Agency, withi incident, and if the all appropriate corrective This REQUIREMENT by: Complaint#: NJ1443  Based on interviews, of other pertinent faci 6/21/2021, it was det failed to report an alle to the New Jersey De (NJDOH), as well as policy titled "Abuse-R for 1 of 3 residents sa deficient practice was Review of the Electro (EMRs)" were as follows a sadmitted to the diagnoses which includes a Brief Interview for Mof	ative and to other officials in e law, including to the State in 5 working days of the eged violation is verified e action must be taken.  Tis not met as evidenced  42  record reviews, and review lity documents on ermined that the facility egation of physical restraint epartment of Health failed to follow the facility's reporting and Investigation" ampled (Resident ). This is evidenced by the following:  Inic Medical Records by:  Itical Record (MR), Resident in the facility on included but were not limited to  mal Data Set (MDS), an included but were not limited to  mal Data Set (MDS) score in resident had included by the following included by the following included by the following included but were not limited to	F 60	Corrective Action: The cited incident was reported to E on 06/21/21.  Identification of Residents at Risk: All residents with incidents a accidents within the facility have the potential of them being reportable incidents. Residents can be identificated reviewing the resident roster.  Systemic Change: Facility administrator will review all incidents and accidents daily or as as possible for one year to identify is a need to report it as required by regulations. The incidents or accide that are identified as reportable will reported to the appropriate parties it timely manner according to federal state regulations.  Quality Assurance: An audit of reportable or non-report incidents, will be conducted and documented quarterly by Administrates designee for one year. Any concern recommendations will be made at the time and addressed as needed. Resthis audit will be reported to the Quarterly will be conducted to the Quarterly will be made at the time and addressed as needed. Resthis audit will be reported to the Quarterly will reported	ed by  soon f there the nts be n a and  able ator or ss/ nat sults of		
	During an interview o	n 6/21/2021 at 10:00 a.m.,			ality		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION	(X3) DATE COMP	SURVEY LETED
		315237	B. WING				C <b>21/2021</b>
	ROVIDER OR SUPPLIER			449 S	ET ADDRESS, CITY, STATE, ZIP CODE PENNSVILLE-AUBURN ROAD NEYS POINT, NJ 08069	, , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 609	the resident was disconcertified Nursing Asson resident's explained to the Survincident to the State is abuse." During the inthe Surveyor with an facility's Administrator documentation revea Resident is family in CNAs tied Resident resident's in the Surveyor with an facility's Administrator documentation revea Resident in the Surveyor with an facility's Administrator revealed that Resident in the Resident in th	alled about one week after harged, indicating two istants (CNAs) tied the together. The DON eyor, "I did not report the because I could not prove terview, the DON presented email from the DON to the redated	F	609			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		TE SURVEY MPLETED
		315237	B. WING		0	C <b>6/21/2021</b>
NAME OF PROVIDER OR SUPPLIER  SOUTHGATE HEALTH CARE CTR				STREET ADDRESS, CITY, STATE, ZIP CODE 449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 08069	1	0/21/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 609	abuse by anyone, incresidents, consultants agencies serving the legal guardians, spor individuals. Under "Al infliction of injury, unrintimidation, or punish harm, pain or mental "Reporting": All incide reported to the admin to the resident's represimmediate investigati findings of such investo the administrator/d Jersey Reportable Expepartment of Health licensing standards or require that facilities in Assessment Survey Laccordance with all a regulations. It is indicinotify the Department "Immediately": by teleconfirmation with 72 Inot limited to any sus	residents to be subjected to cluding staff member, other s, volunteers, staff or resident, family members, sors, friends, or other buse" means the willful easonable confinement, ment with resulting physical anguish Under ents of abuse must be elistrator/designee, as well as esentative (sponsor). An on must be made, and the stigations must be reported esignee Under "New vents": According to the and Senior Services of health care facilities notify the Departments  Unit of reportable events in pplicable State and Federal atted that the facility should to f Health. Under ephone, followed by written mours for the following but pected case of resident which have been reported	F 60			
F 610 SS=D	CFR(s): 483.12(c)(2)- §483.12(c) In respons	Correct Alleged Violation -(4) se to allegations of abuse, or mistreatment, the facility	F 61	0		6/29/21

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315237	B. WING			C <b>06/21/2021</b>		
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	21/2021	
SOUTHGATE HEALTH CARE CTR				4	49 S PENNSVILLE-AUBURN ROAD			
				C	CARNEYS POINT, NJ 08069			
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F 610	Continued From page	e 4	F 6	310				
	§483.12(c)(2) Have eviolations are thorough	evidence that all alleged ghly investigated.						
		nt further potential abuse, or mistreatment while the ogress.						
	designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective. This REQUIREMENT	the results of all administrator or his or her tative and to other officials in the law, including to the State on 5 working days of the leged violation is verified the action must be taken.  This not met as evidenced						
	by: Complaint#: NJ1443	42			Corrective Action: The cited incident was investigated ar	nd		
		record review, and review of y documents on 6/21/2021, it the facility failed to			documented on 6/21/21.  Identification of Residents at Risk:			
	investigate an allegar physically restraint, a facility's policy titled '	tion of a resident being us well as failed to follow the l'Abuse-Reporting and f 3 residents sampled eficient practice was			All residents with allegations o abuse neglect exploitation or mistreatment require an investigation be done. Residents can be identified the reviewing the resident roster.	to		
	·	onic Medical Records			Systemic Change: Facility administrator will review all incidents and accidents daily or as so as possible for one year to identify that			
	According to the Med was admitted to the	dical Record (MR), Resident ne facility on with			proper investigation was performed.	<del></del>		
	diagnoses which incl	uded but were not limited to			Quality Assurance: An audit of investigations, will be conducted and documented quarterly Administrator or designee for one yea Any concerns/ recommendations will I made at that time and addressed as	r.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		PLETED
		315237	B. WING _				C / <b>21/2021</b>
	ROVIDER OR SUPPLIER			44	TREET ADDRESS, CITY, STATE, ZIP CODE 49 S PENNSVILLE-AUBURN ROAD ARNEYS POINT, NJ 08069	1 00	21/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 610	assessment tool date a Brief Interview for M of indicating the cognitive impairment. Resident needed of Activities of Daily Livi  During an interview of the Director of Nursin is family member of the resident was disc Certified Nursing Ass resident's interview, the DON pr an email from the DO Administrator dated documentation revea Resident is family in CNAs tied Resident resident's	d Resident had Mental Status (BIMS) score resident had severe The MDS also showed extensive assistance with ng (ADLs).  n 6/21/2021 at 10:00 a.m., g (DON) stated Resident alled about one week after harged, indicating two istants (CNAs) tied the together. During the resented the Surveyor with N to the facility's  The	F	310	needed. Results of this audit will be reported to the Quality Assurance Committee for one year.		
	family member allege Resident 's room a (him/her). According the DON informed the investigation would be additional details. How DON, no investigation documented.  During an interview of the Surveyor asked the investigated the allegements.	n 6/21/2021 at 11:25 a.m., ne Administrator if he ation made by Resident <b>™</b> 's Administrator stated an ould be investigated.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED	
		315237	B. WING			C 06/24/2024	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  449 S PENNSVILLE-AUBURN ROAD  CARNEYS POINT, NJ 08069	06/21/2021		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 610	being physically Administrator expla call back from the (faccording to the Ad was unable to tell h who did that." The A "did not speak to aremail he received from During a second into a.m., the DON state CNAs about the allefamily member. The interviewed staff, but The DON also states. Review of the facilit "Abuse-Reporting a 4/26/2017, indicated Statement": It is the resident has the riging mistreatment, neglem is appropriation of "Policy Interpretation facility will not permabuse by anyone, in residents, consultar agencies serving the legal guardians, speindividuals. Under "infliction of injury, unintimidation, or puninarm, pain or mental "Prevention": Resider of reprisal to according to the Administration of the province of the Administration of the Administ	abuse allegation for Resident restraint was not done. The ined, "we were waiting on a family member)." However, ministrator, the family member im "what or who was there or Administrator also stated, he by of the CNAs regarding the rom the DON."  erview on 6/21/2021 at 11:35 and, she did not interview any regation made by the resident's and DON explained "I at I did not get statements." and Investigation" dated and Investigation" dated and Investigation and property and abuse. Under nearly and abuse. Under nearly and abuse. Under nearly and abuse. Under neit, exploitation and property and abuse. Under neit, solunteers, staff or the resident, family members, consors, friends, or other Abuse" means the willful inreasonable confinement, shment with resulting physical all anguish Under the ents, families, and staff may be dents and grievances without diministration, social services, visor, and to government	F 6:				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	, ,	TE SURVEY MPLETED
		315237	B. WING _		0	C <b>6/21/2021</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 449 S PENNSVILLE-AUBURN ROAD CARNEYS POINT, NJ 08069		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 610	the staff member resp	ill be conducted to identify consible for the initial n of alleged violations and	F 6			7/0/04
SS=D	CFR(s): 483.70 §483.70 Administration A facility must be administration enables it to use its re- efficiently to attain or practicable physical, and well-being of each res	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial sident. is not met as evidenced	FO	Corrective Action:		7/9/21
	Based on interviews a facility documents on determined that the A ensure that the facility "Abuse-Reporting and for an allegation of a restraint by a facility s practice was for 1 of and was evidenced b Review of the Electro (EMRs) were as follow According to the Med was admitted to the	and review of other pertinent 6/21/2021, it was dministration failed to y's policy for d Investigation" was followed resident being physically staff member. This deficient B residents (Resident ), y the following:  nic Medical Records ws:		The cited incident regarding that resident was investigated and resident was investigated and resident was investigated and resident was investigation working there and an investigation working the completed.  In Service done with Department Director of Nursing, Unit Manage Supervisors, educating them the event which occurs that may be to the state must be brought to the attention of the Administrator or Administrators representative infor a full investigation. In Service done by Regional Administrator facility Administrator and DON resident the need to follow policies on invand reporting allegations. Identification of Residents at Risidents with incident accidents within the facility need.	eported to ints were ras  Int Heads, ers, and eat any reportable the the immediately e was with the egarding vestigating  sk: ints and	

NAME OF PROVIDER OR SUPPLIER  SOUTHGATE HEALTH CARE CTR    (X4) ID   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONST	TRUCTION	(×	(X3) DATE SURVEY COMPLETED		
SOUTHGATE HEALTH CARE CTR    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAGE IT AGE IT A			315237	B. WING _	. WING					
CARNEYS POINT, NJ 08069   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPLETION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	NAME OF P	ROVIDER OR SUPPLIER	-	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP CODE			.,	
CARNEYS POINT, NJ 08069   CARNEYS POINT, NJ 08069   CARNEYS POINT, NJ 08069   CEACH DESCRICTION (CEACH DESCRICTION (CEACH DESCRICTION (CEACH DESCRICTION (CEACH CORRECTION CEACH ON SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES NOTHE APPROPRIATE DEFICIENCY)    F 835	SOUTHO	TE HEALTH CARE CTE			449 S PE	ENNSVILLE-AUBURN ROAD				
F 835  Continued From page 8  Continued From page 8  According to the Minimal Data Set (MDS), an assessment tool dated session in indicating the resident set of Daily Living (ADLs).  The MDS also showed Resident needed extensive assistance with Activities of Daily Living (ADLs).  During an interview on 6/21/2021 at 10:00 a.m., the Director of Nursing (DOD) stated Resident the resident was discharged, indicating two Certified Nursing Assistants (CNAs) tied resident incident to the State because I could not prove abuse. During the interview, the DON presented the Surveyor with an email from the DON to the facility's Administrator dated from the DON to the facility's Administrator dated from the DON to the resident's family member alleged that two CNAs tied Resident was cared and in pain. Further review of the documentation revealed that Resident was scared and in pain. Further review of the documentation revealed the family was scared and in pain. Further review of the documentation revealed the family service of the community of the propertion of them being reportable incidents. Resident and have the potential of them being reportable incidents. Resident dentified by reviewing the resident scan be identified by reviewing the resident toster.  Systemic Change: Facility administrator will review all incidents and accidents daily or as soon as possible for one year to identify that a proper investigation was performed and to identify if there is a need to report it as required by the regulations. Corrective action in service/education will be readdress and resigned annually for Department Heads, Director of Nursing, Unit Managers, and Supervisors.  Quality Assurance: Any concerns/ recommendations will be made at that time and addressed as needed. Results of this audit will be reported to the Quality Assurance. Committee for one year.					CARNE	YS POINT, NJ 08069				
investigated and have the potential of them being reportable incidents.  According to the Minimal Data Set (MDS), an assessment tool dated sees as the seed to preview of the Minimal Data Set (MDS), an assessment tool dated sees as the seed to preview of the mesident seature of them being reportable incidents.  Resident scan be identified by reviewing the resident once as the identified by reviewing the resident sees as be identified by reviewing the resident sees as be identified by reviewing the resident once as be identified by reviewing the resident sees as be identified by reviewing the resident sees deen tesident once as besident or eves all incidents and accidents adily or as soon as possible for one year to identify that a proper investigation was performed and to identify if there is a need to report it as required by the regulations. Corrective action in service/education will be readdress and resigned annually for Department Heads, Director of Nursing, Unit Managers, and Supervisors.  Quality Assurance:  An audit of reportable or non-reportable incidents and their investigations, will be conducted and documented quarterly by Administrator dated incidents	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(	(EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR	ULD BE		COMPLETION	
Resident sor room a while later and untied (him/her).  During an interview on 6/21/2021 at 11:25 a.m., the Administrator stated, "the DON did not report the allegation of abuse." The Administrator explained the DON is the abuse coordinator; "I do understand I am supposed to report an allegation of abuse but, that is the job of the DON."  During a second interview on 6/21/2021 at 11:35	F 835	According to the Min assessment tool date a Brief Interview for I of indicating the Resident interview of the Director of Nursing is family member of the resident was discontified Nursing Assessment's explained to the State abuse." During the interview of the Surveyor with an facility's Administrate documentation reveal Resident is family CNAs tied Resident resident's is family CNAs tied Resident resident's is room a review of the documentation reveal (him/her).  During an interview of the Administrator state allegation of abue explained the DON is understand I am sup of abuse but, that is sident in the state of the state of the poon is understand I am sup of abuse but, that is sident in the state of the poon is understand I am sup of abuse but, that is sident in the state of the poon is understand I am sup of abuse but, that is sident in the poon in the poon in the poon is understand I am sup of abuse but, that is sident in the poon in the	imal Data Set (MDS), an ed  Resident  had Mental Status (BIMS) score e resident had  had so had extensive assistance with ring (ADLs).  In 6/21/2021 at 10:00 a.m., and (DON) stated Resident called about one week after charged, indicating two sistants (CNAs) tied the together. The DON veyor, "I did not report the because I could not prove atterview, the DON presented a email from the DON to the or dated  The alled that on  had to the together. The alled that on  had to the together alleged that two to the scared and in pain. Further entation revealed the family a someone came into a while later and untied  had not report se." The Administrator is the abuse coordinator; "I do posed to report an allegation the job of the DON."	F&	inverther Res the Sys Faccincic as propider required actions action acti	m being reportable incidents. sidents can be identified by rev resident roster.  Stemic Change: cility administrator will review all dents and accidents daily or as possible for one year to identify per investigation was performentify if there is a need to report uired by the regulations. Correction in service/education will be didress and resigned annually fourtment Heads, Director of Nut Managers, and Supervisors.  Ality Assurance: Audit of reportable or non-reported and their investigations, and cucted and documented quarter investigations or the concerns/ recommendations or the concerns/ recommendations or the concerns/ recommendations or the concerns/ recommendations or the concerns/ resolution of this audit will be orted to the Quality Assurance	riewing  II s soon y that a ed and t it as ctive  for ursing,  ortable will be erly by year. will be as be	to		

NAME OF PROVIDER OR SUPPLIER  SOUTHGATE HEALTH CARE CTR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 835  Continued From page 9  a.m., the DON stated, "I'm the abuse coordinator, a reportable was not done. I did not follow the policy."  Review of the facility's policy titled "Abuse-Reporting and Investigation" dated 4/26/2017, indicated the following: Under "Policy Statement": It is the policy of this facility that each resident has the right to be free from	C 06/21/2021 (X5) COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER  SOUTHGATE HEALTH CARE CTR  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 835  Continued From page 9  a.m., the DON stated, "I'm the abuse coordinator, a reportable was not done. I did not follow the policy."  Review of the facility's policy titled "Abuse-Reporting and Investigation" dated 4/26/2017, indicated the following: Under "Policy Statement": It is the policy of this facility that each	(X5) COMPLETION
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mistreatment, neglect, exploitation and misappropriation of property and abuse. Under "Policy Interpretation and Implementation": Our facility will not permit residents to be subjected to abuse by anyone, including staff member, other residents, consultants, volunteers, staff or agencies serving the resident, family members, legal guardians, sponsors, friends, or other individuals. Under "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish Under "Prevention": Residents, families, and staff may report concerns, incidents and grievances without fear of reprisal to administration, social services, nursing, their supervisor, and to government agencies  N.J.A.C.: 8:39–13.1(a)	