STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315231	A. BUILDING _____ B. WING _____	06/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON HEALTH CARE CENTER	535 EGG HARBOR ROAD SEWELL, NJ 08080

(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: 06/25/21 CENSUS: 93 SAMPLE SIZE: 20 + 3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	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 observation, interview, record review and review of facility documentation, it was determined that the facility failed to administer a medication in accordance with professional standards. This deficient practice was identified for 1 of 2 nurses on 1 of 2 units ([redacted] Unit) observed during medication pass 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	This Plan of Correction constitutes Jefferson Health Care Center□s (the Center) written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by federal and state law. It is the practice of the facility to provide services to our patients and residents that meet professional standards. Resident #37 was prescribed [redacted] medication that was not to be crushed. Resident #37 did not receive the crushed [redacted] medication and no	7/8/21

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

Electronically Signed | 07/14/2021

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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." On 06/17/21 at 8:26 AM, the surveyor observed the Licensed Practical Nurse (LPN) administer medications to Resident #37. The LPN dispensed a total of six medications, which included a [redacted] milligram (mg) tablet, a time-released medication used to treat [redacted]. The LPN crushed all of the tablets, mixed them in applesauce and proceeded to the bedside of Resident #37 to administer the medications. At that time, the surveyor stopped the LPN from administering the medications and requested the LPN to return to the medication cart to review the medication orders for Resident #37. At 8:35 AM, the LPN acknowledged that the [redacted] mg tablet should not have been crushed. During an interview on 06/17/21 at 9:40 AM, the Director of Nursing (DON) stated that it was not	F 658	adverse effect occurred. Resident #37 did not experience any adverse effects by this practice. The nurse immediately discarded the crushed [redacted] medication. The nurse then gave it to the resident as per pharmacy recommendations. All residents receiving an [redacted] medication, and those who require their medications to be crushed are at risk to be affected by the practice. Nurse was immediately educated on not crushing [redacted] medications. Resident #37 still resides at the facility in stable condition. All nurses were: (a) immediately educated on the presence of the crush list found on the medication carts, (b) provided with an individualized copy of the crush list (licensed nursing staff and agency nurses), and (c) required to sign off on the contents of the medication crush list. The rationale why certain medications are not to be crushed was also included. Additionally, the pharmacy has designated medications on residents' Medication Administration Record as "no crush". The facility has also contacted its pharmacy consultant regarding any additional considerations in addressing this issue. The Policy and Procedure for crushing medications has been modified in consultation with the pharmacist and the Medical Director. The Clinical Educator/designee educated all nurses not to crush [redacted] medication. This education was completed on July 8, 2021.	

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F 658	Continued From page 2 appropriate to crush [redacted] medications and doing so was not consistent with the facility's policy. The DON further stated that [redacted] formulations should not be crushed because that would cause them to be released into the body's system faster. A review of Resident #37's Physician's Order Sheet (POS) revealed a [redacted] order for [redacted] tablet [redacted] mg daily. A review of Resident #37's 06/2021 Medication Administration Record (MAR) revealed an order dated [redacted] for [redacted] tablet [redacted] mg daily. The MAR further revealed the additional instructions, "do not crush or chew." A review of the facility's "Medication Pass Standards" policy, with the revision date of [redacted], reflected that medications followed by a suffix of [redacted]" were [redacted]) medications. The policy indicated not to crush [redacted] medications. NJAC 8:39-29.2(d)	F 658	The Clinical Educator/designee will perform random audits on residents receiving [redacted] medications to ensure medication is not crushed by observing medication administration by the nursing staff and agency staff. The audits will be performed 5 days a week X 2 weeks, then monthly x2 months. The results of these audits will be presented to the QAPI committee, which meets monthly, for review and revision as deemed necessary.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to	F 689	This Plan of Correction constitutes Jefferson Health Care Center's (the	7/14/21

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F 689	Continued From page 3 consistently follow a physician's order for bilateral floor mats. This deficient practice was identified for 1 of 2 residents reviewed for accidents (Resident #28) and was evidenced by the following: During a tour of the facility on 06/15/21 at 10:56 AM, the surveyor observed Resident #28 with his/her eyes closed in bed, with the head of the bed slightly elevated. The surveyor further observed two [redacted] propped against the wall in front of the resident's bed. The surveyor did not observe [redacted] on either side of the resident's bed. The surveyor made the same observation on 06/16/21 at 10:52 AM. According to the Face Sheet, Resident #28 was admitted to the facility with diagnoses that included but not limited to [redacted] A review of a Quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, dated [redacted], reflected that staff assessed the resident as [redacted] and required extensive assist of two persons for bed mobility and transfers. The resident was also identified as having [redacted] to [redacted]. A review of Resident #28's [redacted] Risk Score, an assessment tool used to score a resident's likelihood of [redacted], dated [redacted] revealed that staff calculated a score of [redacted]" which identified Resident #28 was at high risk for [redacted]	F 689	Center) written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by federal and state law. It is the practice of the facility to ensure that residents environment remains as free of accident hazards as possible, and that each resident receives adequate supervision and assistance to prevent accidents. It was determined that Resident #28 had [redacted] that were not placed on the floor next to the resident's bed while the resident was in bed. Resident #28 and residents who require [redacted] while in bed are at risk to be affected by this practice. Resident #28 still resides at the facility in stable condition. [redacted] were immediately placed on the floor next to resident's bed. Nursing and housekeeping staff were immediately educated on the importance of ensuring that floor [redacted]s are in place whenever a resident who has an order for them is in bed. The Clinical Educator educated all staff to ensure residents who require [redacted] have them on the floor when a resident is in bed. This education was completed on July 8, 2021. Housekeepers were also educated to ensure that while residents' rooms are cleaned, the [redacted] remain in place for safety reasons. This was	

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F 689	Continued From page 4 A review of Resident #28's active Physician Orders (PO) revealed a [redacted] PO for [redacted] on each side of bed before sleep and naps." A review of Resident #28's Care Plan (CP) updated [redacted] reflected that Resident #28 had a "Problem" of [redacted]" The CP further revealed interventions that included [redacted] while in bed." On 06/17/21 at 8:19 AM, the surveyor observed Resident #28 with his/her eyes closed in bed, with the head of bed slightly elevated. The surveyor observed a [redacted] positioned to the right side of the resident's bed but did not observe a [redacted] positioned to the left side of the bed. The surveyor further observed a [redacted] propped against the wall in front of Resident #28's bed. On 06/23/21 at 11:01 AM, the surveyor interviewed the Certified Nurse Assistant (CNA) responsible for caring for Resident #28. The CNA stated that Resident #28 required total assistance with care and was not able to get out of bed by himself/herself. The CNA further stated that the resident had [redacted] that should be positioned on each side of the bed whenever the resident was in bed. During an interview with the surveyor on 06/23/21 at 11:58 AM, the Licensed Practical Nurse (LPN) stated that Resident #28 required extensive assistance with care. The LPN stated the resident's [redacted] should be positioned on each side of the bed whenever the resident was in bed. The LPN further stated the [redacted] were in place as a [redacted] precaution. During an interview with the surveyor on 06/24/21	F 689	completed by July 14, 2021 The unit managers/designee will perform random audit that residents who require [redacted] have them on the floor while residents are in bed. Audits will be conducted 5 days a week X 2 weeks, then monthly x2 months. The results of these audits will be brought to the QAPI committee, which meets monthly for review and revision as deemed necessary.	

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F 689	Continued From page 5 at 12:50 PM, the Director of Nursing stated that she expected the resident's [redacted] to be in place when the resident was in bed. NJAC 8:39-27.1(a)	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		7/8/21

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F 690	Continued From page 6 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility documentation, it was determined that the facility failed to provide appropriate treatment and services related to [redacted] care, in accordance with their policy. This deficient practice was identified for 1 of 1 residents (Resident #14) reviewed for [redacted] care and was evidenced by the following: On 06/16/21 at 12:03 PM, the surveyor observed Resident #14 sitting in the wheelchair in his/her room. The [redacted] was touching the floor. On 06/22/21 at 12:38 PM, the surveyor observed the resident sitting in the wheelchair, in his/her room. The [redacted] was touching the floor. On 06/23/21 at 10:46 AM, the surveyor observed the resident sitting in the wheelchair, in his/her room. The [redacted] and [redacted] were both touching the floor. During an interview with the surveyor on 06/23/21 at 10:57 AM, at the resident's bedside, the Licensed Practical Nurse confirmed the above observation and stated the [redacted] should not be touching the floor. A review of Resident #14's Face Sheet revealed that the resident was admitted with diagnoses including but not limited to [redacted]	F 690	This Plan of Correction constitutes Jefferson Health Care Center's (the Center) written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by federal and state law. It is the practice of the facility to ensure that residents who have [redacted] receive appropriate treatment and services related to [redacted] care in accordance with the facility's policy. Resident #14's [redacted] were observed by the surveyor to be touching the floor. (If [redacted] had been used, there would not have been any opportunity for the [redacted] to be on the floor. Are these in use)? Resident #14 and all residents with an [redacted] are at risk based on this practice. Resident #14 still resides at the facility and is in stable condition. Resident #14's [redacted] and [redacted] were replaced immediately. The Clinical Educator immediately educated staff to ensure [redacted] and [redacted] do not touch the floor as per the facility [redacted] policy.	

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F 690	Continued From page 7 [redacted] During an interview with the surveyor on 06/24/21 at 12:50 PM, the Director of Nursing (DON) stated that the [redacted] and/or [redacted] touching the floor is not consistent with the facility's policy. A review of the facility's "[redacted] Care" policy, revised February 2021, reflected that [redacted] should not be placed on the floor. NJAC 8:39-27.1(a)	F 690	The Clinical Educator educated licensed nurses and CNA to ensure that [redacted] cannot touch the floor. This education was completed on July 8, 2021. The unit managers/designee will perform random audit on residents with [redacted] to ensure [redacted] are not touching the floor. Audits will be conducted 5 days a week X 2 weeks, then monthly x2 months. The results of these audits will be presented to the QAPI committee, which meets monthly for review and revision as deemed necessary.	
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documents, it was determined that the facility failed to provide a sanitary environment for residents, staff and the public by failing to keep the garbage container area free of garbage and debris and failed to have a cover over the opening of 1 of 3 garbage containers/dumpsters. This was cited at a level C, as the deficient practice was cited at the last standard survey of 08/08/2019. This deficient practice was evidenced by the following: On 06/07/21 at 9:50 AM, the surveyor toured the kitchen with the Director of Dietary (DOD) and	F 814	This Plan of Correction constitutes Jefferson Health Care Center's (the Center) written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by federal and state law. It is the practice of the facility to ensure that garbage and refuse are disposed of properly. This practice was not met by failing to keep the garbage container area free of garbage and debris and have a cover/lid that closes.	7/2/21

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F 814	Continued From page 8 requested to see the outside garbage receptacle area. The surveyor observed a garbage container (GC) that was uncovered and exposed to the elements. There was a foul odor noted in the area and a number of flies around the opened GC. The surveyor observed multiple clear white trash bags piled inside of the GC and sticking out of the top. The surveyor further observed that the outside garbage receptacle area was littered with debris, used gloves, milk crates and plastic utensils. When interviewed at that time, the DOD stated that both the housekeeping and dietary departments were responsible for maintaining the outside garbage receptacle area. The DOD further stated that they used the GC for breakfast clean up and that the GC lids would be closed just before lunch. During an interview with the surveyor on 06/10/21 at 11:12 AM, the Director of Housekeeping (DOH) stated the housekeeping department was responsible for maintaining the outside garbage receptacle area. The DOH further stated all staff knew that the GC lids were supposed to be closed when not in use. The surveyor reviewed the facility's "Garbage Area Policy: Procedures" policy, dated 05/05/21, provided by the DOD. The policy indicated the dietary department was responsible for closing lids on the GC. The policy further indicated there would be no trash or debris, including milk crates around the GC. NJAC 8:39-19.3(c)	F 814	All residents are at risk to be affected by this practice. The garbage container was covered immediately. The garbage container area was immediately cleaned. The Facilities Manager and the Director of Dietary educated their staff to ensure the garbage container is covered and the garbage container area remains clean and free of debris. Education took place on June 24, 2021. The Infection Preventionist/designee will audit the garbage containers, and garbage container area to ensure the lid is closed, and area is free of debris. Audits will be conducted 5 days a week X 2 weeks, then monthly x2 months. The results of these audits will be presented to the QAPI committee, which meets monthly for review and revision as deemed necessary.	