STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315528	A. BUILDING _____ B. WING _____	C 06/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEWISH HOME FOR REHABILITATION AND NURSING, THE	1151 WEST MAIN STREET FREEHOLD, NJ 07728

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS COMPLAINT # NJ 151308, 150760 CENSUS: 128 SAMPLE SIZE: 5 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 000		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential	F 842		6/24/22

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

Electronically Signed | 06/22/2022

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 842	Continued From page 1	F 842		

all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

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F 842	Continued From page 2 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: COMPLAINT #: NJ 150760, 151308 Based on interviews, Medical Record (MR) review, and review of pertinent facility documents on 5/27/2022, 5/31/2022 and 6/1/2022, it was determined that the facility failed to follow their, "Charting Documentation." Policy for 2 of 5 sampled residents, (Resident #1, and Resident #4) reviewed for documentation. This deficient practice was further evidenced by the following: 1. According to the Admission Record, Resident #1 was admitted to the facility on [redacted], with diagnosis which included but were limited to: [redacted]. According to the Minimum Data Set (MDS), an assessment tool dated [redacted] Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating that Resident #1 was [redacted]. The MDS also indicated Resident #1 required extensive assistance with Activities of Daily Living (ADLs). A review of Resident #1's MR "Documentation Survey Report Version (V)2" Certified Nursing Assistant (CNA) tasks for December 2021, revealed no documentation completed on all 3 shifts (day, evening and night) from 12/1/2021 to 12/9/2021 on the following task:	F 842	F000 Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the Provider of the truth or the facts alleged, or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State Laws that require it. F842 SS=B 1. CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) – Resident Records-Identifiable Information The medical record of Resident #1 and Resident #4 were affected. All nursing staff, along with Administrator and Director of Nursing have been reeducated on proper required ADL task charting and documentation in the Resident's medical record. 2. All Residents of the facility have the potential to be affected by incomplete ADL task documentation. 3. -Certified Nursing assistants were in-serviced by 6/23 regarding completion of ADL documentation prior to end of their shift. -Nurses were educated by 6/23 to ensure the Certified nursing assistants complete documentation prior to end of shift. -Nursing Supervisor will audit POC documentation prior to end of each shift to	

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F 842	Continued From page 3 Incontinence Care: 19 blanks. Preventative Skin Care: 21 blanks. Turning and Repositioning: 20 blanks. Eating support: 15 blanks. Amount eaten for all 3 meals: 15 blanks. Stop and Watch: 20 blanks. HS snacks: 5 blanks. 2. According to the Admission Record, Resident #4 was admitted to the facility on [redacted], with diagnosis which included but were not limited to: [redacted], and [redacted] According to the Minimum Data Set (MDS), an assessment tool dated [redacted] Resident #4 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated [redacted] The MDS also indicated she was extensive assist to totally dependent with ADLs. A review of Resident #4's MR "Documentation Survey Report V 2" Certified Nursing Assistant (CNA) tasks for September 2021, October 2021, and November 2021, revealed no documentation was completed on all 3 shifts on the following tasks: September 1 through 30, 2021: Incontinence Care, preventive skin care and turning: 43 blanks Eating support: 39 blanks. Amount eaten for all 3 meals: 39 blanks. Stop and Watch: 43 blanks. HS snacks: 20 blanks. October 1 through 31, 2021. Incontinence Care: 60 Preventative Skin Care: 62	F 842	ensure certified nursing assistants' complete documentation on all residents. -UM will review POC documentation during morning clinical to ensure the documentation is completed for previous day. 4. -The Director of Nursing will audit the POC documentation for 10 residents weekly for 4 weeks and then Monthly to ensure 100% compliance of POC Documentation. - The results of the audits will be reviewed during the monthly QAPI Committee meeting. - The QAPI Committee will make recommendations based upon the results of the audits - The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved.	

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F 842	Continued From page 4 Turning and Repositioning: 62 Eating support and amount eaten all meals: 44 Stop and Watch: 62 HS snacks: 24 November 1 to 2, 2021. Incontinence Care: 2 Preventative Skin Care: 2 Turning and Repositioning: 2 Eating support, amount eaten and HS snacks: 2 Stop and Watch: 2 During an interview on 5/31/2022 at 10:05 a.m., the Director of Nursing (DON) stated, if there are blanks on the tasks record no one would know if the care was completed or not. It is the nurse's responsibility to make sure all documentation and care is done at the end of the shift. A review of the facility policy titled "Charting Documentation," under Policy Statement revealed the following: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care..." NJAC 8:39-11.1	F 842		