STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315290	A. BUILDING _____ B. WING _____	C 08/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUCKINGHAM AT NORWOOD, THE	**100 MCCLELLAN STREET NORWOOD, NJ 07648**

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F 000	INITIAL COMMENTS C #: NJ: 134159, 135004, 136760, 138052 Census: 151 Sample Size: 9	F 000		
F 677 SS=B	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: C#: NJ00135004, NJ00134159 Based on interviews and record review, as well as review of pertinent facility documents on 8/13/20, 8/14/20 and 8/17/20, it was determined that the facility failed to document for Activities of Daily Living (ADLs) for 2 of 9 Residents (Resident #1 and #7) reviewed for ADLs. This deficient practice is evidenced by the following: 1. According to the "ADMISSION RECORD (AR)", Resident #7 was admitted to the facility on Exec Order 26 § 4b1 individual's health info . According to the Minimum Data Set (MDS), an assessment tool, dated Exec Order 26 § 4, Resident #7 had Exec Order 26 § 4b1 individual's health info and required extensive assistance from staff with ADLs. The "Care Plan (CP)" initiated on 2/4/20 showed that the Resident presented with decreased	F 677	F677 SS=B 1.HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE. 1) Resident #1 and Resident # 7 are no longer in the facility. Staff#1 LPN and CNA #1 were provided with 1:1 education on their job descriptions and responsibilities. 2. Staff LPN #1 and CNA #1 were provided 1:1 education on completion and accuracy of the ADL tracking form on 8/18/20 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents were identified as having the	9/3/20

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/09/2020

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F 677	Continued From page 1 performance in ADLs and transfers. The "ADL Tracker" dated 3/2020 showed no documentation that Resident #7 was assisted with bed mobility, transfer, eating and toilet use on 3/5/20 to 3/11/20, 3/13/20 to 3/20/20, 3/22/20, 3/23/20, and 3/29/20 during the evening (3:00 pm to 11:00 pm shift) and on 3/28/20 and 3/29/20 during the morning (7:00 am to 3:00 pm) shift. The Progress Notes (PNs) for Resident #7 for 3/2020 showed that staff assistance with ADLs was not documented on the aforementioned dates. 2. According to the AR, Resident #1 was admitted to the facility on Exec Order 26 § 4, with diagnoses that included but were not limited to: Exec Order 26 § 4b1 individual's health info. According to the MDS, dated Exec Order 26, Resident #1's had Exec Order 26 § 4b1 individual's health info and required extensive assistance from staff with ADLs. The CP initiated on 6/11/20 showed that the Resident had ADL self care performance deficit. The intervention included, but was not limited to: two staff participation with transfers. The "ADL Tracker" dated 2/2020 showed no documention that Resident #1 was assisted with bed mobility, transfer, and toilet use on 2/28/20 during the night (11:00 pm to 7:00 am) shift. The Progress Notes (PNs) for Resident #1 for 2/2020 showed that staff assistance with ADLs was not documented on the aforementioned date.	F 677	potential to be affected by this deficient practice. 3.WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. 1) The Facility Educator provided education for nursing staff(CNAS and Nurses) regarding the completion and accuracy of ADL Trackers beginning 8/18/20. Education is ongoing. 2) The DON provided the 11-7 am Nursing Supervisor with education on ADL Tracker auditing on 8/18/20. 3)As of 8/18/20 the Facility Educator or designee will educate staff upon orientation, annually and as needed, on how to complete and utilize an ADL tracking Form. 4. Audits will be conducted by 11-7 am Nursing Supervisor or designee on ADL Tracker completion and Accuracy by observing 10 ADL Tracking daily x4 weeks;10 ADL Trackers weekly X8 Weeks; 10 ADL Trackers monthly X3 months; and then 10 ADL trackers quarterly X3 quarters 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR,I.E.,WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE.	

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F 677	Continued From page 2 The surveyor conducted an interview with the Certified Nursing Assistant (CNA #1) on 8/13/20 at 6:45 am. She stated that nurses and cnas documented on the ADL Tracker form and without documentation it meant ADLs were not provided. The surveyor conducted an interview with Licensed Practical Nurse (LPN #1) on 8/17/20 at 10:43 am. The LPN revealed that nurses were responsible for documenting on ADL forms. She stated that if there were blanks on the ADL Tracker form, that meant that the care was not provided. The facility's job description for Certified Nurse Aide showed that: "...RESPONSIBILITIES/ACCOUNTABILITIES ...3 Provides maximum resident care services...5 Bathes the resident in bed, tub or shower, combs hair, cleans and cuts fingernails and gives shampoos...13 Assists all residents with their meals and provides in between meal nourishment...14 Answers resident's call light or bell, delivers messages, administers bedpans and urinals...20 Receives...charts, records...". The facility's job description for Licensed Practical Nurse, revised on 9/06, showed that: "...RESPONSIBILITIES/ACCOUNTABILITIES...3 Responsible for clinical documentation related to resident activity;...9 Supervises and coordinates nursing personnel in providing direct resident care...11 Performs other duties as requested..." The facility's job description for Registered Nurse, revised on 9/06, showed that: "...RESPONSIBILITIES/ACCOUNTABILITIES...2 Supervises and coordinates nursing personnel in	F 677	DON will report results of these audits to the QAPI Committee Quarterly for recommendations and review of trends. 5. COMPLETION DATE 9/3/2020	

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F 677	Continued From page 3 providing direct resident care...13 Maintains accurate resident care records and documents pertinent data reflecting the use of nursing process;..." The facility's policy titled "ADL CARE" dated 01/2012 and revised on 10/2019 showed that: "It is the policy of this facility to provide ADL care to residents requiring such assistance to ensure all ADL needs are met on a daily basis ..."	F 677		
F 745 SS=D	NJAC 8:39-27.2 (h) Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: C#: NJ00136760 Based on interviews, review of the medical records, as well as review of other pertinent facility documentation on 8/14/20, 8/15/2020, and 8/17/20, it was determined that the Director of Social Services (DSS) failed to: Identify medically related social needs for a resident and assist a resident/family in obtaining needed services from outside entities, as required by the facilities "Job Description for the Social Services Director", for 1 of 3 residents (Resident #4). This deficient practice was evidenced by the following: 1. According to the "ADMISSION RECORD (AR)", Resident #4 was admitted to the facility on Exec Order 26 § 4, with diagnoses that included but were	F 745	F745 SS=D 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE 1) Resident #4 is no longer I the facility. 2) The Administrator reviewed the job description with SW Director. 3. The Administrator provided 1:1 re education on Discharge Planning Process and Policy including the creating of and updating Discharge care Plans on 9/8/20 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE	9/10/20

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F 745	Continued From page 4 not limited to: Exec Order 26 § 4b1 individual's health info . The Minimum Data Set (MDS), an assessment tool dated Exec Order 26 § 4b, showed that Resident #4 had a Brief Interview for Mental Status (BIMS) score of Exec Order 26 § 4b1 individual's health info and required extensive assistance with Activity of Daily Living (ADL). The Resident "Baseline Care Plan v1.0 [version 1.0] (BCPv1.0)" dated 3/25/20 under the discharge goals showed that Resident had to return to the community. However, this CP did not reflect interventions which was not according to the facility's policy. The surveyor conducted an interview with the Social Worker (SW) on 8/17/20 at 11:53 am, he stated that he was responsible for creating and updating the CP for discharge. The SW further stated that he failed to create and update the CP because of the current situation related to Covid-19. The "Progress Notes (PN) dated 3/27/20 at 5:27 pm documented by the SW showed that Resident #4 lived alone in an apartment and had to go home with home health care service. The form "IDCP [Interdisciplinary Care Plan] Care Partner Team Going Home Note" showed that on 5/3/20 the Resident was educated on wound care. Under the Physician's summary documented by the Primary Physician (PP) on 5/6/20 showed that the Resident had to be discharged home with home care services. The PN date 5/8/20 at 6:28 pm showed	F 745	SAME DEFICIENT PRACTICE. 1. An Audit was done on 9/8/20 of all Sub acute residents by the Director of Social Work to confirm that all Discharge Plans were in place, on going. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. 1) The Administrator provided education for social work Team regarding the completion and accuracy of Medical Discharge Care Plans and Discharge Planning Policy, completed 9/8/20 education ongoing. 2) The Administrator provided the Social Work Director with Tracker Auditing Tool to track referrals to agencies on 9/4/20. . Home Care Log created to track specific patients and resources recommended. 4) Follow-up phone call within 24 hours of D/c to ensure proper follow through Re : Home Care and DME and tracked by receptionist/Concierge weekly and reported to SS Director. 5. Audits will be conducted by the Social work Director or designee on 5 charts weekly x4 weeks;x3 months;X3 quarters and reported weekly in The Ambassador meeting. 4.HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E.	

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F 745	Continued From page 5 "discharge home via ambulance transport". The form "RESOLUTION TO RESIDENT GRIEVANCE/COMPLAINT FORM (RRGCF)" dated 5/11/20 showed that the facility received a telephone call from Resident #4's Representative (RR) stating that Resident #4 did not receive home health care services for 48 hours. The RRGCF further showed that the Home Health Care Agency (HHCA) did not receive the referral from the Facility. The surveyor reviewed the referral to HHCA dated 5/7/20 from the Social Worker showed that Resident #4 was for Exec Order 26 § 4b1 individual's health info and the Face to Face Encounter (FFE) form (requirement for the certification of eligibility for Medicare home health services, by requiring the certifying physician to document that he or she, or a non-physician, has seen the patient) was to be faxed the following day after Primary Physician signed the form. The Medical Record did not indicate that the FFE was faxed to the HHA the following day (5/8/20, the day of discharged to home). The surveyor conducted an interview with Social Worker (SW) on 8/18/20 at 3:16 pm. He stated that the he called the HHA to confirm if they received the aforementioned referral forms. However, he did not confirm with the HHA if the HHA would accept the Resident for home care services. Furthermore, he stated that the FFE form was not sent to the HHA until 5/11/20, instead of 5/8/20, the day the Resident was discharged to home. Post survey, the surveyor conducted a telephone interview with the Registered Nurse (RN) from	F 745	WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE. 1. Social Work Director will ensure that all documentation on referrals to agencies are documented in the clinical record and in tracking record and report results of these audits to the QAPI Committee quarterly for review of trends and recommendations. 2. Pre UR-Meeting conducted with SS present to ensure all team members are aware of specific D/c needs of patients. 3. A QAPI on DC TRACKING FORMS will be completed by Social Work Director Quarterly and reported to the QA Committee Quarterly x4. 5.COMPLETION DATE 9/10/20	

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F 745	Continued From page 6	F 745		

the HHA on 8/17/20 at 4:31 pm. The RN stated that the aforementioned forms that were faxed were received from the SW. However, their agency (HHA) did not receive the FFE form which was required under Medicare eligibility for the HHA to provide home health provide services to Resident #4.

Post survey, the surveyor conducted a telephone interview with the Intake Coordinator Manager (ICM) from the HHA on 8/18/20 at 12:27 pm. The ICM stated that without the FFE form completed by the PP the patient will not be accepted to receive services from the HHA which was discussed with the SW on 5/8/20 prior to the discharge to home.

The surveyor reviewed the FFE provided by the HHA on 8/18/20, the FFE form showed that the FFE was completed and signed by the PP and faxed to the HHA on 5/11/20. The FFE further showed that the PP certified that the Resident was homebound and required daily wound care and dressing changes on the Resident's right knee every day.

Review of the "Job Description" under "Position Title: SOCIAL SERVICE DIRECTOR ...The Social Services Director plans and assists in research projects and is responsible for discharge planning/community resources ...8. Assists each resident with adjustment to the social and emotional aspects of placement by including clearly defined Social Service goals/interventions in the care plan ...10. Acts as a liaison between residents, families and outside agencies, and the facility Administrator, to ensure that the resident's rights are maintained;...12. Functions in a management capacity and

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F 745	Continued From page 7	F 745		

adheres to all policies/procedures of the facility as a representative of the [name of the facility] administration;...14. Coordinates discharge planning, including the development of an organized discharge plan for all residents...17. Perform other duties as requested..."

According to a facility policy titled "DISCHARGE PLANNING PROCESS POLICY" dated 01/2012 and 11/2017 showed under policy "It is the policy of this facility to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care..."Discharge planning" is a process that generally begins on admission and involves identifying each resident's discharge goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the resident's stay to ensure a successful discharge...5. If discharge to community is a goal, an active discharge care plan will be implemented and will involve the interdisciplinary team, including the resident and/or resident representative. The plan shall be documented on resident's care plan...8. The facility will document any referrals to local contact agencies or other appropriate entities made for the purpose of the resident's interest in returning to the community. 9. The facility will update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities...11. The evaluation of the resident's discharge needs and discharge plan will be completely documented on a timely basis in the clinical record..."

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F 745	Continued From page 8 NJAC 8:39-39.4(e)(f)(i)	F 745		