STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315061	A. BUILDING _____ B. WING _____	C 06/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D 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 136755 CENSUS: 113 SAMPLE SIZE: 5 Based on observations, interviews, review of the Medical Records (MR), and other pertinent facility documentation on 6/8/2020, it was determined that the facility staff failed to ensure a resident was protected from actual abuse, as well as, failed to follow the Facility's Policies titled "Resident Abuse Policy" and "Abuse Prevention Program," to prevent abuse and report abuse after the incident, for 1 of 5 residents sampled, (Resident #2), when on 6/3/2020 as viewed on the Facility's Security Camera, Resident #2 was roughly handled when a staff member forcefully pulled back the resident's wheelchair causing the resident to fall forward out of the chair, subsequently fell to the floor, and sustained an abdominal injury. A second staff member then forcefully grabbed the resident by the upper arm, causing the resident to be held down in the wheelchair while the 1st staff member roughly pushed the resident backwards in the wheelchair returning the resident to their room. The resident was sent to the hospital complaining of [redacted] and was admitted on [redacted], with a diagnosis of [redacted]. This deficient practice placed Resident #2 and all other residents who were at risk for abuse in an Immediate Jeopardy (IJ) situation. The IJ was identified on 6/8/2020 at 6:58 p.m., when the Facility's Regional MDS (Minimum Data Set) Coordinator (RC) and the Regional Nurse	F 000		

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

Electronically Signed 07/06/2020

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 000	Continued From page 1 Consultant (RNC), were notified of the IJ and were provided the IJ template. The IJ ran from 6/3/2020 through 6/10/2020 at 11:52 a.m., and was lifted when the facility provided an acceptable Removal Plan.	F 000		
F 600 SS=L	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ 136755 Based on observations, interviews, review of the Medical Records (MR), and other pertinent facility documentation on 6/8/2020, it was determined that the facility staff failed to ensure a resident was protected from actual abuse, as well as, failed to follow the Facility's Policies titled "Resident Abuse Policy" and "Abuse Prevention Program," to prevent abuse and report abuse after the incident, for 1 of 5 residents sampled, (Resident #2), when on 6/3/2020 as viewed on	F 600	F-600 1. A full investigation was started on 6-8-2020 by the Corporate Consultant. The employee BT (Behavioral Tech #1) was immediately suspended pending investigation. An immediate interview was done with resident #2 by the Corporate Consultant and Social Service Director on 6-8-2020. Individual counseling was done on 6/8/2020 and 6/9/2020 by the Corporate Consultant to all Nursing Administration as well as Department Heads in regards to Abuse and Abuse Reporting. The Nurses agency that	6/25/20

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F 600	Continued From page 2 the Facility's Security Camera, Resident #2 was roughly handled when a staff member forcefully pulled back the resident's wheelchair causing the resident to fall forward out of the chair, subsequently fell to the floor, and sustained an [redacted]. A second staff member then forcefully grabbed the resident by the upper arm, causing the resident to be held down in the wheelchair while the 1st staff member roughly pushed the resident backwards in the wheelchair returning the resident to their room. The resident was sent to the hospital complaining of [redacted] and was admitted on [redacted], with a diagnosis of [redacted]. This deficient practice placed Resident #2 and all other residents who were at risk for abuse in an Immediate Jeopardy (IJ) situation. The IJ was identified on 6/8/2020 at 6:58 p.m., when the Facility's Regional MDS (Minimum Data Set) Coordinator (RC) and the Regional Nurse Consultant (RNC), were notified of the IJ and were provided the IJ template. The IJ ran from 6/3/2020 through 6/10/2020 at 11:52 a.m., and was lifted when the facility provided an acceptable Removal Plan. This deficient practice was further evidenced by the following: 1. According to the Face Sheet, Resident #2 was admitted to the Facility originally on [redacted], and readmitted on [redacted], with diagnoses which included but were not limited to: [redacted] Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], revealed Resident #2 had a Brief Interview for Mental	F 600	employed the 11-7 nurse was contacted on 6-8-2020 and informed that this nurse would no longer work for this company. The other 3 Behavioral techs were terminated and no longer work at the facility. A call was placed to the Reportable hotline at 7pm on 6-8-2020 by the Regional Nurse and AAS form was started. Police were notified as to the event and all information required by them was rendered on 6-10-2020. 2. All residents have the potential to be affected by this deficient practice when Abuse and Abuse Reporting policies are not followed. 3. All staff were in-serviced on 6-8-2020 in regards to Abuse and Abuse Reporting on 6-8-2020 by the Regional Nurse. On 6-11-2020 all staff received printed information in regards to Abuse and Abuse reporting and Chain of Command by the Regional Nurse and Corporate Consultant. All contact numbers for Department Heads were updated and reviewed so that Chain of Command was accurate and Chain of Command was posted at each Nurses station on 6-9-2020 by the Regional Nurse. On 6-25-2020 a Sensitivity in-service was done for all staff by the Nurse educator a Sensitivity brochure was given to all staff members. 4. The Director of Nurses, Assistant Director of Nurses and Nurse Educator will in-service all staff weekly x 3 months on Abuse Policy and Abuse Reporting,and Chain of Command then monthly x 3	

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F 600	Continued From page 3 Status (BIMS) score of [redacted]. The MDS also indicated Resident #2 needed only supervision for Activities of Daily Living (ADLs). Review of the "Resident Plan of Care" (CP) dated 1/24/2020, revealed a [redacted] history. The Goals listed included but were not limited to: The resident will continue to [redacted] safely. The interventions included but were not limited to: Resident may [redacted] unsupervised. Further review of the CP revealed Resident #2 had a history of aggressive behavior. The Goals listed included but were not limited to: The resident will exhibit less aggression and outburst.... The interventions included but were not limited to: Psychology consults, Social worker will visit 1:1 as needed to provide emotional support and encourage resident to verbalize feelings about being a resident at the facility. 2. According to the Face Sheet Resident #4 was admitted to the Facility on [redacted], with diagnoses which included but were not limited to: [redacted] Review of the MDS an assessment tool dated [redacted] revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of [redacted] The MDS also indicated Resident #4 needed only supervision for Activities of Daily Living (ADLs). Review of Resident #4 "Interdisciplinary Care Plan" with a last review date of 10/16/2018, revealed under "Behavior/Mental" that the resident was alert and oriented.	F 600	months. All policies on Abuse and Abuse Reporting as well as Chain of Command will be included in all orientation literature upon hire and reviewed by the Nurse Educator during the orientation period. All findings will be reviewed at the Quality Assurance Meeting x 4 quarters.	

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F 600	Continued From page 4 Review of the "Resident Plan of Care" (CP), undated, revealed a Problem listed: "Prefers the quiet and comfort of his own room." 3. During an interview on 6/8/2020 at 12:21 p.m., Resident #2 reported that on 6/3/2020, during the evening, he/she went to the nursing station and requested to go out for a [redacted][1]. The resident stated there was an argument between him/her and "the guy at the nursing station" (Behavioral Tech#1.) BT#1 kept telling the resident to go back to his/her room. When the resident refused to go to their room, the staff member (BT#1) came behind him/her and pushed the resident from the wheelchair. The resident reported he/she fell forward to the floor and hit his/her stomach. After the fall there was a verbal argument between the resident and the staff member. The resident then reported he/she was pushed a second time and fell again when the staff member pulled his/her arm. The resident reported the following to the nurse, "He pushed me and I'm in [redacted], I need to go to the hospital it hurts." According to the resident, the nurse looked at his/her stomach. "I remember the nurse said to the guy, (staff member) "Leave the guy alone." The resident reported the nurse sent him/her to the hospital on [redacted] and he/she had "lots of test" and "was given pain medications...." During the interview on 6/8/2020 at 12:21 p.m. Resident #2 showed this writer [redacted][1]. Observed was a discoloration to the [redacted] approximately [redacted] Resident #2 pointed to the discoloration of the [redacted][s] and stated, "this is what he did," referring to the BT#1.	F 600		

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F 600	Continued From page 5 During an interview on 6/8/2020 at 12:40 p.m., Resident #4 (Resident #2's room-mate) stated that on 6/3/2020 in the evening, there was some noise outside the room, and he/she witnessed a staff member pushing Resident #2 "twice." Resident #4 also stated, "I heard him/her yell when he/she fell, and he/she complained of a lot of pain." Resident #4 then stated, he/she heard the nurse say they were going to send Resident #2 to the hospital. Review of the Facility's "Nurse's Notes" dated 6/3/2020, untimed, the nurse documented the following: Resident #2 complained of [redacted] The doctor was made aware and the nurse received an order to send the resident to the hospital for an evaluation. The documentation was signed by the Regional Nurse Consultant (RNC). Review of the Physician Order Sheet (POS), dated 6/3/2020, untimed, the nurse documented a physician's order (PO) to send Resident #2 to the Emergency Room (ER) for an evaluation and treatment which was signed by the RNC. According to the "Incident Report" dated 6/3/2020 at 4:30 a.m., documented under "Describe exactly what happened," The Licensed Practical Nurse (LPN #1) documented the following: The resident was in the hallway "(after being warned)" the Behavior Techs (BTs), were attempting to return the resident to his/her room. Under "Type of Injury," [redacted] was checked. On the body diagram the LPN placed a mark to the [redacted] LPN #1 also reported Resident #2's level of consciousness as "AAOx3" (alert	F 600		

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and oriented times 3) which refers to a patient who is responsive to his or her environment (alert), and knows person, place and time.

During an interview on 6/8/2020 at 12:53 p.m., the Regional MDS Coordinator (RC) reported, that she had no knowledge of any allegation of staff to resident abuse in the facility on [redacted]s The RC also verified at that time that she was the nurse that wrote the PO on the POS to transfer the resident to the ER, "it was a late entry. I told the nurse when someone goes out you need to write the order. I don't remember who I said it to." The RC further stated that she was not sure if the incident was investigated. "It would be the responsibility of the nurse on duty, the supervisor, and the Director of Nursing (DON) to complete an investigation of any alleged abuse."

During an interview on 6/8/2020 at 1:00 p.m., the Facility's RNC reported, that she had no knowledge of any alleged abuse, staff to resident, in the facility on 6/3/2020. In addition, she stated the facility does not have a night Supervisor, but someone would be designated as the "Charge Nurse." of the Facility. In addition, the RNC reported the DON has been out since 5/28/2020.

During an interview on 6/8/2020 at 2:52 p.m., the Admission Office Director (AOD) reported that the hospital social worker calls the Facility to let them know when a resident is ready to be discharged and returned back to the facility.

During an interview on 6/8/2020 at 2:56 p.m., the Admission Assistant (AA) reported that she spoke to someone at the hospital on [redacted]. The hospital representative stated Resident #2 agreed to return to the facility if the employee who hurt [redacted] was no longer employed there. The AA also

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identified the employee by [redacted] name (BT #2) and stated she spoke to the nurse on "[redacted] unit" regarding the resident's return but was unable to identify the nurse by name.

During an interview on 6/8/2020 at 3:25 p.m., the Registered Nurse (RN)/Supervisor reported that she was informed by another staff member on 6/4/2020 of the altercation between a resident and a staff member on 6/3/2020. The RN stated, that she was informed that the resident was belligerent and fell out of his wheelchair and was later sent to the hospital with bruises. She also stated that the BTs were involved in the incident. In addition, the RN stated she viewed the incident report and when the resident returned to the facility from the hospital the resident showed her the bruises. The RN was unable to say if anyone reported the incident to Administration and that she did not report it. The RN/Supervisor also verified that she was in-serviced on abuse when she started working at the facility last November.

During an interview on 6/8/2020 at 3:42 p.m., BT #2 reported that on 6/3/2020, he heard the nurse arguing with Resident #2, around 3:00 or 4:00 a.m.,"he/she wouldn't wear a mask." The nurse then asked him to assist her to wheel the resident back to their room. The resident was being uncooperative when they attempted to take him/her back to their room. "I did not put my hands on [redacted] at all." When they reached the doorway, the resident stood up and BT #2 reported he grabbed the resident for safety, but the resident did hit the railing with the right side of the body and upper arm. BT #2 also stated, He grabbed the resident's arm when he/she stood up for safety, so the resident did not fall. BT#2 also verified that he was in-serviced on abuse one month prior.

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Review of the Facility's Security Camera recording on 6/8/2020 at 4:30 p.m., with the RNC, revealed the following: Resident #2 was observed entering the hallway from his/her room at 2:34 a.m., the resident self-propelled the wheelchair (w/c) towards the nursing station, a few seconds later the resident returned to their room. At 2:46 a.m., Resident #2 again propels the wheelchair back down the hall towards the nursing station. Observed on the video, a few seconds later Resident #2 was sitting in the w/c and BT #1 steps behind the w/c and forcefully pulls the w/c back causing the resident to fall forward onto the floor. A few seconds later Resident #2 was observed back in his w/c after the fall, and BT #2 forcefully grabbed the resident's left upper arm pulling him/her by the arm while BT #1 stood in front of the w/c and forcefully pushed the resident backwards towards their room. Once the staff returned the resident to the room two other staff members appear in view of the camera and walk down the hall to the resident's room. The Facility Administration was able to identify all four staff members present during the incident.

During an interview on 6/8/2020 at 5:00 p.m., BT #2 identified himself on the Facility's Security Camera as the one who grabbed Resident #2's arm and forcefully pulled the resident to the room. BT #2 stated, "I told you I did grab him/her." When asked: Was it with force? BT #2 responded, "I guess it was." BT #2 also admitted he took the resident back to their room against his/her will.

During an interview on 6/8/2020 at 5:28 p.m., the Facility's RC and RNC agreed that it was inappropriate for the nurse to document "after being warned" on the incident report because it

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could be considered verbal abuse. In addition, the RNC reported Peggy's Law should have been implemented after the incident as well as, the nurse should have done a head to toe assessment on the resident, sent all four involved home, then called 911 for allegations of abuse. In addition, the doctor should have been notified and statements should have been obtained from the resident and all witnesses also the Charge Nurse on the shift should have been notified of the incident.

Review of the Hospital's "History and Physical" (H&P) dated [redacted], revealed the following documentation by the Physician, under "History of Present Illness,"... [redacted] "
He/she was being quarantined due to testing [redacted] 4 days ago. The patient stated "The guy wouldn't let him/her leave then pushed him/her" while in the wheelchair, and he/she fell onto the ground hitting [redacted] abdomen. The resident reported [redacted] was noted on the [redacted] The resident also complained of [redacted] .... The H&P further showed under "Physical Exam," [redacted]

Review of the Hospital Records [redacted] date [redacted] at 5:51 a.m., revealed the following results: [redacted] ." Under Impression: 2. " [redacted] ."

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Review of the Hospital Records Nursing Documentation on [redacted] and [redacted], the nurses documented the following on Resident #2: "Pt (patient) yelling out in pain when changed position in bed from side to side. Pt complaining of [redacted]. Pt refused [redacted] Pt refused [redacted]."

Review of the Facility's "Nurse's Notes" revealed documentation on [redacted] at 5:15 p.m., that Resident #2 returned from the hospital and was readmitted to the Facility.

Review of the Police Investigation Report dated 6/10/2020 at 8:20 a.m., the Patrolman (PM), documented he was dispatched to the Facility for an assault on a patient by an employee. The PM spoke to the Facility's RNC who informed him that Resident #2 was assaulted by 2 nursing aids which resulted in the resident having to go to the hospital for injuries. The PM reviewed the video recording of the incident with the RNC and documented the incident. The PM was given the names of the employee's involved however, after speaking with Resident #2 who confirmed his/her injuries with the PM, the resident stated he/she did not want any further police involvement and the resident confirmed he/she was satisfied the Aides were relieved of their employment at the facility.

Review of the facility policy titled "Abuse Prevention Program," with a review date of 4/20/2020, under "Policy Statement," listed the following: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or

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physical abuse, and physical or chemical restraint not required to treat resident's symptoms.

Review of the Facility's "Resident Abuse Policy" undated, which was signed by BT#1 on 4/13/2020, BT#2 on 5/5/2020, BT#3 on 4/4/2020, and BT#4 on 4/13/2020, and found in their employee file as in-serviced. The Policy included but was not limited to the following: "It is the policy of the facility to take appropriate steps to ensure that all alleged violations of Federal or State laws which involve mistreatment, neglect or abuse (verbal, sexual, physical and mental), and misappropriation of resident property ("alleged violations") are reported to the Administrator of the Facility. Anyone witnessing or suspecting any type of abuse towards a resident by any individual, including staff, family,... will immediately, report the violation to the supervisor on duty." This form was signed by the four BT's indicating that they had read and understood the resident abuse policy and knew their responsibilities regarding preventing resident abuse and reporting requirements.

Resident #2 was roughly handled when a staff member forcefully pulled back the wheelchair causing Resident #2 to fall forward out of the wheelchair, and subsequently fell to the floor, and sustained an abdominal injury. A second staff member then forcefully grabbed the resident by the upper arm causing the resident to be held down in the wheelchair while the other member roughly pushed the resident backwards in the wheelchair returning him/her to their room against their will. The resident was sent to the hospital requiring treatment of an [redacted] The resident was admitted to the hospital on [redacted], with a diagnosis of

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SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 12 [redacted]. This deficient practice placed Resident #2 and all other residents who were at risk for abuse in an Immediate Jeopardy (IJ) situation. The IJ was identified on 6/8/2020 at 6:58 p.m., when the Facility's Regional MDS Coordinator (RC), and the Regional Nurse Consultant (RNC), were notified of the IJ and were provided the IJ template. The IJ ran from 6/3/2020, through 6/10/2020 at 11:52 a.m., and was lifted when the facility provided an acceptable Removal Plan. A revisit to verify the Removal Plan occurred on 6/12/2020.	F 600		
F 609 SS=F	NJAC: 8:39-4.1 (a) 5 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.	F 609		7/7/20

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F 609	Continued From page 13 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ 136755 Based on interviews, review of the Medical Records (MR), and other pertinent facility documentation on 6/8/2020, it was determined that the facility staff failed to report an allegation of abuse to the New Jersey Department of Health (NJDOH), as well as follow their own facility policy titled "Abuse Investigation and Reporting," for 1 of 5 sampled residents (Resident #2) reviewed for incidents. This deficient practice is evidenced by the following: 1. According to the Face Sheet, Resident #2 was admitted to the Facility originally on [redacted], and readmitted on [redacted], with diagnoses which included but were not limited to: [redacted] Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted]	F 609	1. The AAS-45 form for resident #2 was completed and faxed to the Department of Health Office on 6-9-2020 by the Corporate Consultant. Behavior Tech # 1 was immediately suspended and on 6-10-2020 terminated via phone by the Corporate Consultant. 2. All residents have the potential to be affected by this deficient when the Abuse and Abuse reporting policies are not followed. 3. All staff were in-serviced on Abuse and Abuse Reporting policies on 6-8-2020 by the Regional Nurse. On 6-11-2020 all staff received printed information in regards to Abuse and Abuse reporting and Chain of Command by the Regional Nurse and Corporate Consultant. All contact numbers for Department Heads were updated and reviewed so that Chain of Command was accurate and Chain of Command was posted at each Nurses station on 6-9-2020 by the Regional Nurse. On 6-25-2020 a Sensitivity in-service was done for all staff by the Nurse educator a Sensitivity brochure was given to all staff members.	

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F 609	Continued From page 14 [redacted]. The MDS also indicated Resident #2 needed only supervision for Activities of Daily Living (ADLs). Review of the "Incident Report" dated 6/3/2020 at 4:30 a.m., The Licensed Practical Nurse (LPN #1) documented the following: The resident was in the hallway "(after being warned)," the Behavior Techs (BTs), were attempting to return the resident to his/her room. Under "Type of Injury," [redacted] was checked. On the body diagram the LPN placed a mark to the left upper quadrant area to indicate where the [redacted] was on the body. There was no documentation on the form to indicate the Nursing Supervisor or Administration was notified of the incident. During an interview on 6/8/2020 at 12:21 p.m., Resident #2 reported on 6/3/2020, he had an argument with a staff member (Behavioral Tech#1) about staying in his room. When the resident refused, 2 staff members (BTs) became aggressive with the resident and pushed the resident from the wheelchair. The resident reported he/she fell onto to the floor and injured his/her stomach. The resident reported he was pushed a second time and fell again. The resident stated he/she reported the incident to the nurse and asked to go to the hospital for pain and an injury to the abdomen. According to the resident the nurse looked at his/her stomach. Resident #2 also stated, "I remember the nurse said to the guy (BT), Leave the guy alone." The resident was sent to the hospital on [redacted], and admitted with a diagnosis of [redacted] During an interview on 6/8/2020 at 12:53 p.m., the Facility's Regional MDS Coordinator (RC) reported she had no knowledge of any allegation	F 609	4. The Director of Nurses, Assistant Director of Nurses and Nurse Educator will in-service all staff weekly x 3 months on Abuse Policy and Abuse Reporting, and Chain of Command then monthly x 3 months. All policies on Abuse and Abuse Reporting as well as Chain of Command will be included in all orientation literature upon hire and reviewed by the Nurse Educator during the orientation period. All findings will be reviewed at the Quality Assurance Meeting x 4 quarters.	

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F 609	Continued From page 15	F 609		

of staff to resident abuse in the facility on 6/3/2020. She also stated it is the policy of the facility to report any abuse allegations to the NJDOH however, she was not aware of any abuse.

During an interview on 6/8/2020 at 2:56 p.m., the Admission Assistant (AA) reported, that she spoke to someone at the hospital on [redacted]. The hospital representative stated Resident #2 agreed to return to the facility if the employee who hurt him was no longer employed there. The AA also identified the employee by his name (BT #1) and stated she spoke to the nurse on '[redacted] unit" regarding the resident's return but was unable to identify the nurse by name.

During an interview on 6/8/2020 at 3:25 p.m., the 3-11 Registered Nurse (RN)/Supervisor stated, that she was informed by another staff member on 6/4/2020, of the altercation between a resident and a staff member on 6/3/2020. She also stated she saw the incident report, and after the resident returned from the hospital the nurse saw the [redacted]. The RN was unable to say if anyone reported the incident to Administration and that she did not report it because she was not there when it happened.

During an interview on 6/8/2020 at 4:20 p.m., the Assistant Director of Nursing stated the following: After the incident report was completed by the nurse, she should have reported the incident to the Supervisor. The Supervisor should have started an investigation and reported the incident to the Administration.

During an interview on 6/8/2020 at 5:28 p.m., the Facility's Regional Nurse Consultant (RNC) reported, that Peggy's Law should have been

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F 609	Continued From page 16 implemented after the incident as well as, the nurse should have done a head to toe assessment on the resident, sent all four staff members involved home, and called 911 for allegations of abuse. In addition, the doctor should have been notified and statements should have been obtained from the resident and all witnesses, also the Charge Nurse on the shift should have been notified of the incident and the New Jersey Department of Health (NJDOH) should have been notified. Post survey, a Facility Reportable Event (FRE) Form was sent to the NJDOH by the Facility via fax on 6/10/2020, reporting the abuse incident. Review of the facility policy titled "Abuse Investigation and Reporting," with a review date of 4/20/2020, under "Policy Statement," listed the following: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported.	F 609		
F 610 SS=F	N.J.A.C. 8:39-9.4 Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610		6/25/20

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F 610	Continued From page 17 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ 136755 Based on interviews, review of the Medical Records (MR), and other pertinent facility documentation on 6/8/2020, it was determined that the facility staff failed to investigate an allegation of abuse, as well as, failed to follow the facility policy titled "Abuse Investigation and Reporting," for 1 of 5 sampled residents (Resident #2). This deficient practice is evidenced by the following: 1. According to the Face Sheet, Resident #2 was admitted to the Facility originally on [redacted] and readmitted on [redacted] with diagnoses which included but were not limited to: [redacted] Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], revealed Resident #2 had a Brief Interview for Mental	F 610	1. A full investigation was started on 6-8-2020 by the Corporate Consultant. The employee BT (Behavioral Tech #1) was immediately suspended pending investigation. An immediate interview was done with resident #2 by the Corporate Consultant and Social Service Director on 6-8-2020. Individual counseling was done on 6/8/2020 and 6/9/2020 by the Corporate Consultant to all Nursing Administration as well as Department Heads in regards to Abuse and Abuse Reporting. The Nurses agency that employed the 11-7 nurse was contacted on 6-8-2020 and informed that this nurse would no longer work for this company. The other 3 Behavioral techs were terminated Resident #2 AAS-45 form was faxed to the Department of Health Office on 6-9-2020 by the Corporate Consultant. Behavior Tech # 1 was immediately suspended and on 6-10-2020 terminated via phone by the Corporate Consultant. The other 2 employees were already terminated as of 6-5-2020 when the program for Behavioral Techs was eliminated. The agency for the 11-7 nurse	

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F 610	Continued From page 18 Status (BIMS) score of [redacted], indicating Resident #2 was [redacted] The MDS also indicated Resident #2 needed only supervision for Activities of Daily Living (ADLs). During an interview on 6/8/2020 at 12:21 p.m., Resident #2 reported on 6/3/2020, he had an argument with a staff member (Behavioral Tech#1). The staff member (BT#1) kept telling the resident to go back to his/her room. When the resident refused, the staff member went behind the wheelchair and pushed the resident from the chair. The resident reported he fell forward to the floor and hit his/her stomach. After the fall there was a verbal argument between the resident and the staff member. The resident then reported he was pushed a second time and fell again. The resident reported the incident to the nurse, and asked to go to the hospital stating, he/she had [redacted]. According to the resident the nurse looked at his/her [redacted]. Resident #2, also stated, "I remember the nurse said to the guy, "Leave the guy alone." The resident was sent to the hospital on [redacted] and admitted with a diagnosis of [redacted] An investigation was started by the Administration on 6/08/2020 the day of the survey. It was determined by review of the Facility's Security Cameras the incident occurred on 6/3/2020 at 2:46 a.m., four staff members were involved and identified. The Facility notified the Local Police on 6/10/2020. During an interview on 6/8/2020 at 5:28 p.m., the Facility's Regional Nurse Consultant (RNC) reported, that Peggy's Law should have been implemented after the incident as well as, the nurse should have done a head to toe	F 610	was called by the Corporate Consultant on 6-9-2020 and they were informed that the nurse could no longer work for the company. The other Behavioral Tech was terminated on [redacted] but had not worked in the nursing department since 6-5-2020. 2. All residents have the potential to be affected by this deficient practice when the policy for Peggy's Law is not followed. 3. All staff were in-serviced on the policy for Peggy's Law and the Law was reviewed in entity with all Department Heads and Nursing supervisors by the Corporate Consultant on 6-9-2020 4. The Director of Nurses and Regional Nurse will in-service all staff monthly x 3 months then every 6 months ongoing on the policy of Peggy's Law. A copy of Peggy's Law along with the policy for Peggy's Law will be included with each employee hire packet.	

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F 610	Continued From page 19	F 610		

assessment on the resident, sent all four staff members involved home, and called 911 for allegations of abuse. In addition, the doctor should have been notified and statements should have been obtained from the resident and all witnesses, also the Charge Nurse on the shift should have been notified of the incident and started an investigation.

Post survey a Facility Reportable Event (FRE) Form was sent to the NJDOH by the Facility via fax on 6/10/2020, reporting the abuse incident.

Review of the Police Investigation Report dated 6/10/2020 at 8:20 a.m., the Patrolman (PM), documented he was dispatched to the Facility for an assault on a patient by an employee. The PM spoke to the Facility's RNC who informed the PM that Resident #2 was assaulted by 2 staff members which resulted in the resident having to go to the hospital for injuries. The PM reviewed the video recording of the incident with the RNC and documented the incident. The PM was given the names of the 4 employee's involved however, after speaking with Resident #2 who confirmed his/her injuries with the PM, the resident stated he/she did not want any further police involvement and the resident confirmed he/she was satisfied the 4 staff members were relieved of their employment at the facility.

Review of the facility policy titled "Abuse Investigation and Reporting," with a review date of 4/20/2020, under "Policy Statement," listed the following: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated

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F 610	Continued From page 20 by facility management. Findings of abuse investigations will also be reported. N.J.A.C. 8:39-9.4	F 610		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ 136755	F 657	1. The Care Plan for resident # 2 was updated by the Regional Nurse on 6-9-2020.	7/7/20

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F 657	Continued From page 21 Based on interviews, review of the Medical Records (MR), and other pertinent facility documentation on 6/8/2020, it was determined the facility staff failed to update and/or revise a resident's Care Plan (CP) to address the needs of the resident to include mood and behavior problems and implement appropriate interventions for safety, for 1 of 5 residents sampled (Resident #2), as well as failed to follow the facility's policy titled "Using the Care Plan." This deficient practice was evidenced by the following: 1. According to the Face Sheet, Resident #2 was admitted to the Facility originally on [redacted] and readmitted on [redacted], with diagnoses which included but were not limited to: [redacted] Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted]. The MDS also indicated Resident #2 needed only supervision for Activities of Daily Living (ADLs). Review of the Facility document untitled and dated December 2019, which is a monthly review sheet completed by the nurse to monitor a residents "target behaviors" for prescribed [redacted] medications (meds), the documentation showed the following diagnosis for the meds, [redacted]	F 657	2. All residents have the potential to be affected by this deficient practice when Care Plans are not updated timely. A review of 10 Care Plans for updates were reviewed by the Director of Nurses and none were found to be deficient. 3. All nurses were in-serviced by the Director of Nurses on 6-12-2020 on the policy and procedure of updating Care plans. 4. The Director of Nurses, Assistant Director of Nurses, and Unit Managers will review 10 charts weekly x one month and 3 charts monthly x 6 months to ensure that care plans are updated on a timely basis. All findings will be reviewed at the Quality Assurance Meeting x 2 quarters.	

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F 657	Continued From page 22 behaviors of "[redacted]" Review of the "Resident Plan of Care" (CP), undated, revealed "Problems" of aggression and mood stabilization. The Goals listed included but were not limited to: The resident will exhibit less aggression and outburst.... The interventions included but were not limited to: Psychology consults, Social worker will visit 1:1 as needed to provide emotional support and encourage resident to verbalize feelings about being a resident at the Facility. The last review date on the behavior CP was 9/27/2019. However, there were no documentation to address the number of episodes of "Target Behaviors" as listed on the behavior monitoring forms for December 2019 and January 2020. Review of the Facility's Policy titled "Using the Care Plan," with a review date of 9/2/2019, under "Policy Statement" listed the following: The Care Plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. The Unit Manager along with the Interdisciplinary team is responsible to update Care Plans. N.J.A.C. 8:39-11.2 (2)	F 657		

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SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

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H5790	8:43E-13.4(d) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer Form sent with a patient when a patient is transferred as part of the patient's medical record. This REQUIREMENT is not met as evidenced by: COMPLAINT: # NJ 136755 Based on interviews, review of the Medical Records (MR), and other pertinent facility documentation on [redacted], it was determined that the facility failed to maintain a copy of the Universal Transfer Form (UTF) as part of the medical record, for 1 of 5 sampled residents (Resident #2), transferred/discharged out of the facility, as well as failed to follow the Facility's Policy titled "Transfer or Discharge, Emergency" This deficient practice was evidenced by the following: 1. According to the Face Sheet, Resident #2 was admitted to the Facility originally on [redacted], and readmitted on [redacted], with diagnoses which included but were not limited to: [redacted]	H5790	1. An investigation in regards to the missing Universal Transfer sheet for resident #2 was started immediately on [redacted] by the Unit Secretary, and Regional Nurse it was unable to be located. 2. All residents have the potential to be affected by this deficient practice when the policy for Universal Transfer forms is not being followed. A review of the last 10 resident's charts that were transferred to the hospital was reviewed for Universal Transfer sheets and none were found to be deficient. 3. An in-service was done for all Nurses by the Director of Nurses on 6-11-2020 in regards to the policy for Universal Transfer sheets. 4.All resident's charts transferred to the hospital will be reviewed by the Assistant Director of Nurses and Unit Managers x 30 days then twice a month x 3 months. All findings will be reviewed at the Quality	7/7/20

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

Electronically Signed | 07/06/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060602	A. BUILDING: _____ B. WING _____	C 06/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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H5790	Continued From page 1 Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted]. The MDS also indicated Resident #2 needed only supervision for Activities of Daily Living (ADLs). Review of the Physician Order Sheet, revealed an order dated [redacted], untimed, documented by the nurse to send Resident #2 to the Emergency Room (ER), for an evaluation and treatment which was signed by the Regional MDS (Minimum Data Set) Coordinator (RC). Review of the Facility's "Nurse's Notes" revealed documentation on [redacted], untimed, that the nurse documented the following: Resident #2 complained of [redacted]. The doctor was made aware and the nurse received an order to send the resident to the hospital for an evaluation. During an interview on 6/8/2020 at 5:28 p.m., the RC reported, that she was unable to locate a copy of the UTF from Resident #2's chart for the transfer to the hospital on [redacted]. She also stated, that a copy of the UTF should be retained in the Medical Record. Review of the Facility's Policy titled "Transfer or Discharge, Emergency," with a reviewed date of 9/8/2019, under "Policy Statement" listed the following: Emergency transfers or discharges may be necessary to protect the health and/or well-being of the residents. Section 4 listed the following: Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution; our facility will implement the following procedures: d. Prepare a	H5790	Assurance Meeting x 3 quarters	

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H5790	Continued From page 2 transfer form to send with the resident.	H5790		