

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/01/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315288	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/12/2023
NAME OF PROVIDER OR SUPPLIER BARTLEY NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 175 BARTLEY RD JACKSON, NJ 08527		
(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#: NJ162053 CENSUS: 203 SAMPLE SIZE: 3 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000			
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the	F 626		10/3/23	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/05/2023

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 626	<p>Continued From page 1</p> <p>requirements of paragraph (c) as they apply to discharges.</p> <p>§483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.</p> <p>This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ162053</p> <p>Based on interviews, medical records review, and review of other pertinent facility documentation on 9/12/23, it was determined that the facility failed to follow their policies and procedures for a facility-initiated discharge. A resident (Resident #1) was involved in an [REDACTED] with another resident and sent to the hospital for a [REDACTED] evaluation. When the resident was discharge from the hospital, the facility would not permit a return back to the facility.</p> <p>The deficient practice was identified for Resident #1, 1 of 3 residents reviewed for transfer/discharge and was evidenced by the following:</p> <p>According to the "Admission Record," Resident #1 was admitted to the facility on [REDACTED] with diagnoses which included but were not limited to [REDACTED]</p>	F 626	<ol style="list-style-type: none"> 1. Resident number 1 does not reside at the facility. The regional administrator provided individual counseling to the facility administrator in regards to the policy titled discharge/transfers. The policy was reviewed with the medical director, Administrator, and Director of Nursing for any need for revisions. 2. All residents have the potential to be affected by this deficient practice when the policy for discharge/transfers is not followed appropriately. 3. The Management, which includes Administrator, Director of Nursing, Assistant director of nursing, Unit managers, Nurse supervisors and Social Worker, were in-serviced on the facility policy and procedure for discharges and transfers. 4. All unplanned discharge/transfers will be reviewed within 48 hours by the Administrator and Director of Nursing or designee to ensure all guidelines and directives are met under the 		

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F 626	Continued From page 2 Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [REDACTED], revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of [REDACTED] which indicated the resident had [REDACTED]. The MDS also showed that the resident had no behaviors. Review of Resident #1's [REDACTED] "PASRR Level II Determination Notification," (Pre-Admission Screening and Resident Review) (a comprehensive evaluation required as a result of a positive Level I Screening and is necessary to determine whether placement or continued stay in a nursing facility is appropriate) reflected that the resident had [REDACTED] treatment needs that could be met at a nursing facility. The following recommendations were made for Resident #1: [REDACTED] consult upon admission, routine follow-up visits with primary care provider and [REDACTED] t, [REDACTED] [REDACTED] formulate and implement a [REDACTED] modification plan to address any [REDACTED], provide education to client and family on [REDACTED] and medication, and develop a [REDACTED] [REDACTED] plan with the client." Review of Resident #13's Care Plan (CP) revealed a "Focus," initiated on [REDACTED], that Resident #1 used psychotropic medications ([REDACTED]) and [REDACTED]) related to [REDACTED] management and [REDACTED]. Under "Interventions/Task," indicated to monitor	F 626	discharge/transfer policy for 60 days. All findings will be reviewed at the Quality Assurance meetings for two quarters.		

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F 626	<p>Continued From page 3</p> <p>occurrences of target behavior symptoms and to document per facility protocol. Target behaviors included [REDACTED] towards staff and others. The CP revealed a "Focus," initiated on [REDACTED] that Resident #1 was admitted to [REDACTED]. Under "Interventions/Tasks," reflected to administer medications per physician's order. The CP revealed a "Focus," initiated on [REDACTED], that the resident was at risk for adjustment due to new admission to long term care placement. Under "Interventions/Tasks," reflected to encourage resident to discuss [REDACTED]s, monitor for triggers that may indicate need to adjust plan of care to assist the resident in compliance, and to monitor reaction to placement.</p> <p>Review of Resident #1's Incident Report, dated [REDACTED] at 11:36 PM, completed by the Registered Nurse Supervisor (RNS), revealed that she was called to the unit and informed that Resident #2 was on the floor in Resident #1's room. The RNS spoke with Resident #1, who stated that Resident #2 came into their room and that he/she asked the resident to leave. Resident #1 further stated that Resident #2 put their [REDACTED] and that he/she had to defend themselves. Resident #1 hit Resident #2 in [REDACTED] and the resident [REDACTED] the [REDACTED]. Under the "Immediate Action Taken" section revealed that Resident #1 was determined to be the [REDACTED] and was transferred to the [REDACTED] Emergency Screening Services (PESS) at the local hospital for evaluation.</p> <p>During an interview with the Licensed Practical</p>	F 626			

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F 626	<p>Continued From page 4</p> <p>Nurse/Unit Manager (LPN/UM) on 9/12/23 at 12:42 PM, the LPN/UM stated that Resident #1 required limited assistance with activities of daily living. The surveyor asked about Resident #1's behaviors. The LPN/UM responded that Resident #1 would at times display [REDACTED] and be [REDACTED] towards staff and [REDACTED]. The LPN/UM continued that Resident #1 also would "shadow box" ([REDACTED]) in the day room. The LPN/UM stated that she was informed of the [REDACTED] incident by the nurse and that Resident #1 was transferred to PESS for evaluation. The LPN/UM added that Resident #1 did not return to the facility.</p> <p>During an interview with the Director of Social Services (DSS) on 9/12/23 at 2:14 PM, the DSS stated that Resident #1 was admitted to the facility from the community with [REDACTED] issues. The resident was transferred out for an evaluation at [REDACTED] due to the [REDACTED] incident. The DDS stated that Resident #1 was on [REDACTED] and the facility [REDACTED] felt that it was not an appropriate medication to be manage at the facility. The DDS further stated that the facility [REDACTED] was uncomfortable with managing Resident #1 while on that particular medication [REDACTED]. An administrative meeting was conducted to discuss the facility's ability to manage Resident #1 behaviors at the facility and discussions were also conducted with [REDACTED] in reference to the medication. The DDS added that they were willing to allow Resident #1 to return to the facility, but the concern was the medication. The resident was eventually admitted to another facility.</p>	F 626			

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F 626	<p>Continued From page 5</p> <p>During an interview with the RNS on 9/12/23 at 2:48 PM, the RNS stated that she was the nursing supervisor during the [REDACTED] incident and that she interviewed Resident #1 about what happened. The RNS stated Resident #1 informed her that Resident #2 entered his/her room and that he/she asked Resident #2 to leave the room. Resident #1 stated that the other resident [REDACTED] him/her and in return had [REDACTED] Resident #2 back. A body assessment was completed for both residents. Resident #1 did not have injuries, but the other resident had injuries. The physician was called, and Resident #1 was sent out for a [REDACTED] evaluation at the hospital. The RNS stated she initiated [REDACTED] of Resident #1 until transferred out.</p> <p>During an interview with the DON and Administrator on 9/12/23 at 3:02 PM, the DON stated that Resident #1 had an [REDACTED] another resident. The DON added that with Resident #1 [REDACTED] Resident #2, along with his/her diagnosis of [REDACTED], and use of [REDACTED] they felt Resident #1's readmission would be unsafe for the other residents. The Administrator stated the facility psychiatrist was not comfortable with [REDACTED] being administered within the long-term care (LTC) setting and felt there was a danger to the other residents. The Administrator reiterated that the facility [REDACTED] was worried for the safety of the other residents on the unit. The surveyor asked when the last time Resident #1 was evaluated by the facility [REDACTED]. The Administrator stated the resident was admitted to the facility on [REDACTED] in [REDACTED] and that he could not remember if the current facility [REDACTED] evaluated the resident prior to the incident. The surveyor inquired about Resident #1's</p>	F 626			

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F 626	Continued From page 6 readmission to the facility after the [REDACTED] evaluation was completed. The Administrator responded that he was in communication with the hospital the entire time and that the facility physician wanted Resident #1 to be admitted as in-patient, so the resident would be weaned off of [REDACTED]. The Administrator stated he was in constant communication with [REDACTED] and never stated that they were not going to take Resident #1 back. At that point in time, they were uncomfortable taking the resident back. They would be more comfortable readmitting the resident after the resident stabilized during an in-patient stay. The Administrator further stated [REDACTED] gave them a hard time about admitting the resident and wanted the resident to return to the facility the same day. The Administrator further stated that he spoke with the [REDACTED] supervisor and inform her that they could not accommodate Resident #1. They were worried about the other residents and the facility [REDACTED] did not want to prescribe the medication [REDACTED]. Once Resident #1 had the [REDACTED] and was sent out for the [REDACTED] evaluation, the physicians did not feel comfortable continuing the medication. The Administrator added that both the facility [REDACTED] and the primary physician did not want to prescribe the medication [Clozaril]. The Administrated stated that he was back and forth with [REDACTED] and at a certain point the resident was admitted. The surveyor asked if Resident #1 was issued a 30-day discharge notice. The Administrator stated that Resident #1 was not issued a discharge notice because the discharge was immediate. The resident just needed to be stabilized and weaned off the medication so that the facility psychiatrist would them take him/her back on. The surveyor asked what were Resident #1's behaviors and if the resident had	F 626			

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F 626	<p>Continued From page 7</p> <p>any other [REDACTED] while at the facility. The DON stated that Resident #1's behavior included [REDACTED] and at times would come up close to people's [REDACTED]. The DON added that Resident #1 did not have any other [REDACTED] while at facility.</p> <p>During an interview with the facility [REDACTED] on 9/12/23 at 4:10 PM, the facility [REDACTED] stated that he was not sure why the resident's medication was being referenced and that this had nothing to do with [REDACTED]. He was informed that Resident #1 [REDACTED] another resident on the unit, and it was more about the safety of the other residents. The resident could end up [REDACTED] another resident and that there were other facilities that could handle the resident.</p> <p>Review of Resident #1 Progress Notes (PN) from [REDACTED] revealed a "Behavior Note," (BN) dated [REDACTED] at 10:30 PM, that Resident #1's [REDACTED] med [medication] changed, [REDACTED] increased from [REDACTED] mg to [REDACTED] mg. No adverse reactions noted. No behavior issues noted throughout the shift." The PN revealed a second BN, dated [REDACTED] at 6:52 PM, that Resident #1 was [REDACTED]. The resident was [REDACTED] at staff. "Redirected when necessary." The PN did not include any physician documentation of the specific needs that could not be met at the facility for Resident #1. The PN also did not include any documentation of the facility's attempts to meet the Resident #1's needs.</p> <p>Review of the facility's [REDACTED] "Reportable Event Record/Report," (Reportable) provided by the Director of Nursing (DON), included an "Investigational Summary" (IS) of the [REDACTED]</p>	F 626			

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F 626	Continued From page 8 incident. The IS reflected under the "Conclusion" section that "based on the facility's thorough investigation, interviews of the resident and staff involved, it was concluded that the [REDACTED] [REDACTED] were triggered by [Resident #2] entering [Resident #1's] room." Resident #1 indicated that Resident #2 hit him/her but there were no witnesses to corroborate the allegation. The IS indicated that "The incident was an isolated event and there were no prior altercations that were reported." The IS included a CP with a "Focus," initiated on [REDACTED] that Resident #1 was [REDACTED] [REDACTED] Easily gets [REDACTED] when someone enters into [his/her] room weather a staff member or another resident." Under the "Goals" section reflected that Resident #1 would demonstrate effective [REDACTED] skills, seek out staff/caregiver when [REDACTED] occurs, [REDACTED], verbalize understanding of need to control [REDACTED] behavior through the review date. Under "Interventions/Tasks," included the following interventions, initiated on [REDACTED] administer medications as ordered, analyze time of day, places, circumstances, triggers, and what de-escalates behavior and document. Provide physical and verbal cues to [REDACTED]; give [REDACTED], assist verbalization of source of [REDACTED] assist to set goals for more pleasant behaviors, encourage seeking out of staff member when [REDACTED] When the resident becomes [REDACTED] Intervene before [REDACTED]; guide away from source of distress; Engage calmly in conversation; If response is [REDACTED], staff walk calmly away and approach later." The IS also included a [REDACTED] Service Notes [REDACTED]), dated 2/10/23 at 9:23 AM, completed by the facility [REDACTED] t for Resident	F 626			

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F 626	<p>Continued From page 9</p> <p>#1. Under the "Plan/Recommendation" section indicated to continue with current treatment, [REDACTED] level, [REDACTED] consult to review need for [REDACTED] e (medication used to treat [REDACTED]), and to follow up in one month. The risks and benefits of treatment were considered, and the recommendations were reviewed with staff." The [REDACTED] did not reveal any documentation that Resident #1's needs could not be met at the facility.</p> <p>Review of Resident #1's "Transfer/Bed Hold Notice Prior to Hospitalizations or Therapeutic Leave" form, dated [REDACTED], reflected that the resident's belongings would be safeguarded until resident's return. The resident "currently occupies a Medicaid covered bed. Per State regulation, your bed must be held for 10 days at no charge for hospitalizations and 24 days per calendar year for therapeutic leave."</p> <p>Review of the facility's "Transfer/Discharges," last revised on 11/2002, reflected that the "Purpose" was to protect the rights of each resident in accordance with state and federal guidelines and applicable laws in regard to transfers and discharges from and to the facility. The policy revealed under the "Facility elected transfer/discharges" section that a resident and/or legal representative will be given a 30-day advance notice of an impending transfer or discharge from the facility, except as specified below: "a. The transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility, c. The safety of other residents and employees is endangered, d. The health of residents and employees in the facility would otherwise be endangered. The resident, and/or legal representative will be provided with</p>	F 626		

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F 626	Continued From page 10 the reason for the transfer or discharge, and the effective date of the transfer or discharge. "The resident and/or legal representative has the right to appeal transfer or discharge notices through the State agency and appeals must be filed within five days of receiving the notice. NJAC 8:39 4.1(a)32 NJAC 8:39 5.1(d)	F 626		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315288	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 10/6/2023	Y3
NAME OF FACILITY BARTLEY NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 175 BARTLEY RD JACKSON, NJ 08527		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0626	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 483.15(e)(1)(2)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	10/03/2023	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/12/2023		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		