STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315375	A. BUILDING _____ B. WING _____	C 05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS CENTER FOR REHABILITATION AND HEALING	497 MT PROSPECT AVE NEWARK, NJ 07104

(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 #s: NJ 162381 NJ 161269 NJ157892 Census: 94 Sample Size: 4 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(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		7/18/23

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

Electronically Signed | 06/15/2023

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 609	Continued From page 1 §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: C#: NJ: 162381 Based on interviews, and record review, as well as review of pertinent facility documents on 5/10/23, it was determined that the facility failed to immediately investigate and report to the New Jersey Department of Health (NJDOH) an injury of unknown origin and follow the facility policy titled "Resident Abuse and Neglect Reporting and Investigation" for 1 of 3 residents (Resident #3) reviewed for incidents and accidents. This deficient practice is evidenced by the following: The facility's policy titled "Resident Abuse and Neglect Reporting and Investigation," undated, indicated "Policy Statement...Any abuse will be reported and thoroughly investigated...Procedure...d...facility shall report the alleged abuse to...all other applicable state agencies...SIGNS/SYMPTOMS OF ABUSE AND NEGLECT PHYSICAL ABUSE BY OTHERS...Other injuries of an unknown source..." 1. According to the "ADMISSION RECORD," Resident #3 was admitted to the facility on [redacted] with diagnoses that included but were not limited to: EX Order 26 § 4b1 [redacted]. The Minimum Data Set (MDS), an assessment	F 609	F609 Corrective Action Resident #3 was discharged RN #1 identified on the statement of deficiency, received in-service training on 5/11/2023 regarding proper documentation, completion of incident report, investigation and reporting of incident/Accident of injury of unknown origin resident #3 incident was investigated and was reported to the new jersey department of health as an injury of an unknown origin identification of other residents affected by the deficient practice all residents has the potential to be affected by this deficient practice the nursing administration audited and reviewed the medical records for all residents assigned to the RN identified in the statement of deficiency to determine if they were affected by the deficiency. no other residents were identified to be affected preventive measures: the centers policy and procedure for	

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F 609	Continued From page 2 tool, dated 2/24/23, revealed a Brief Interview of Mental Status (BIMS) of [redacted] which indicated the resident's EX Order 26 § 4b1 [redacted] The "Progress Notes" (PN) dated 3/13/23 at 12:29 pm, documented by a Registered Nurse (RN #1), reflected "Pt [patient] had [redacted] EX Order 26 § 4b1 [redacted]. As per grand [son/daughter he/she] did not have it yesterday [3/12/23]..." At 1:15 pm, "...Noted a small EX Order 26 § 4b1 [redacted] ...No incident report found..." The PN, date 3/13/23 at 11:07 pm, documented by RN #2 indicated that at approximately [redacted], FMs called Emergency Medical Service (EMS) to pick up Resident #3 to be transferred to an EX Order 26 § 4b1 [redacted] RN #1 was not available for interview on 5/10/23. The surveyor conducted an interview with Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 5/10/23 at 1:54 pm. The DON revealed that RN #1 did not investigate when the FM reported that Resident #3 had EX Order 26 § 4b1 [redacted]. The DON further stated that the incident was not reported to the NJDOH and it should have been reported to NJDOH because the incident was "an Ex.Order 26.4(b)(1)" The ADON stated that the incident was reported to her, however, the ADON was unable to explain why was the incident was not reported to the NJDOH. Review of the policy titled "Incident/Accident	F 609	incident/accident and reporting of injury of unknown origin were reviewed by Administrator and Director of nursing. it was determined that policy and procedure were sufficient and required no changes or modifications. in addition, all nurses and all facility staff received in-service training on 5/11/2023 regarding proper documentation, completion of incident report investigation and reporting of incident/Accident of injury of unknown origin Quality assurance: the Quality assurance performance committee shall be responsible for ascertaining the effectiveness of the corrective actions and preventive measures. Nursing administration shall review the 24-hour summary clinical notes daily for a period of 3 months to identify any potential incident/Accident of unknown origin. the results of their findings will be reviewed weekly by the QAPI coordinator who shall then verify that any injury of unknown origin was properly investigated and reported to the administrator and to the state survey agency. upon completion of the Three months the QAPI committee along with nursing Administration shall be responsible for the review of the facility compliance regarding Incident/Accident investigation and reporting	

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F 609	Continued From page 3 Policy & Procedure", undated, reflected "When an incident or accident occureds, a reporting instrument is initiated for review by appropriate departments...An incident / accident sheet is initiated when an incident / accident occurs including but not limited to unknown injury - all unknown injury should be reported to administrator, DON / designee..." NJAC 8:39-9.4(f)	F 609		
F 842 SS=D	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 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	F 842		7/18/23

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F 842	Continued From page 4	F 842		

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;
(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.

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F 842	Continued From page 5 This REQUIREMENT is not met as evidenced by: C #: NJ00161269 NJ00157892 Based on interviews, medical record review, and review of other pertinent facility documents on 5/10/23, it was determined that the facility staff failed to consistently document in the "Documentation Survey Report" (DSR) the Activities of Daily Living (ADL) status and care provided to the resident according to facility policy and protocol for 2 of 4 residents (Resident #1 and Resident #2) reviewed for documentation. This deficient practice was evidenced by the following: Review of a facility policy titled "Charting and Documentation", undated, reflected "Policy Interpretation and Implementation 1. All observations, medications administered, serviced performed, etc., must be documented in the resident's clinical records..." 1. According to the facility "Admission Record (AR)," Resident #1 was admitted on Ex.Order 26.4(, with diagnoses that included but were not limited to: EX Order 26 § 4b1 . The Minimum Data Set (MDS), an assessment tool, dated 3/8/23, revealed a Brief Interview of Mental Status (BIMS) of EX O which indicated the resident's EX Order 26 § 4b1 and the EX Order 26 § 4b1 . Review of Resident #1's DSR (ADL Record) and the progress notes (PN) for the month of 4/2023 and 5/2023, lack any documentation to indicate that the care for toileting was provided and/or the	F 842	Corrective Action: incomplete activities of daily living in the Documentation survey report that were identified in the statement of deficiency for resident #1 and resident #2 were completed by the residents certified nursing assistant on 5/11/2023 certified nursing assistants identified on the statement of deficiency received in-service training on 5/11/2023 regarding proper, consistent and completed documentation of residents activities of daily living and care provided to the residents on the residents medical records in the documentation survey report/ADL task tab Identification of other residents affected by the Deficient practice: all residents has the potential to be affected by this deficient practice Nursing Administration audited and reviewed the residents Document Survey Report of the activities of daily living status and care provided to all the residents on 5/11/2023 in order to identify other residents that may have been affected by this deficient practice. It was determined that other residents were identified to be affected by this deficient practice. all certified nursing assistants assigned to all affected residents were identified and notified and completed their documentation survey report in the ADL tasks tab on 5/11/2023 Preventive measures:	

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F 842	Continued From page 6 resident refused care on the following dates and shifts; 7:00 am-3:00 pm shift on 4/1/23, 4/3/23, 4/5/23 to 4/11/23, 4/13/23, 4/14/23, 4/17/23 to 4/30/23, 5/1/23, 5/3/23, 5/4/23, 5/7/23, and 5/9/23. 3:00 pm-11:00 pm shift on 4/2/23 to 4/4/23, 4/6/23, 4/9/23, 4/10/23, 4/25/23, 4/26/23, and 4/29/23, 4/30/23, 5/1/23, and 5/7/23. 11:00 pm-7:00 am shift on 4/1/23 to 4/8/23, 4/14/23 to 4/16/23, 4/18/23 to 4/22/23, 4/26/23 to 4/30/23, 5/1/23 to 5/3/23, and 5/5/23 2. According to the facility AR, Resident #2 was admitted on Ex.Order 26.4(b)(1, with diagnoses that included but was not limited to: EX Order 26 § 4b1 [redacted] The MDS, dated 3/2/23, revealed a BIMS of 3 which indicated the resident's cognition was EX Order 26 § 4b1 [redacted]. Review of Resident #2's DSR and the PN for the month of 4/2023 and 5/2023, lack any documentation to indicate that the care for toileting was provided and/or the resident refused care on the following dates and shifts; 7:00 am-3:00 pm shift on 4/1/23, 4/3/23, 4/5/23 to 4/11/23, 4/13/23, 4/14/23, 4/17/23 to 4/30/23, 5/1/23, 5/3/23, 5/4/23, 5/7/23, and 5/9/23. 3:00 pm-11:00 pm shift on 4/2/23 to 4/4/23, 4/6/23, 4/9/23, 4/10/23, 4/25/23, 4/26/23, and 4/29/23, 4/30/23, 5/1/23, and 5/7/23. 11:00 pm-7:00 am shift on 4/1/23 to 4/8/23, 4/14/23 to 4/16/23, 4/18/23 to 4/22/23, 4/26/23 to 4/30/23, 5/1/23 to 5/3/23, and 5/5/23	F 842	Administrator and Director of Nursing reviewed the center policy and procedure regarding charting and documentation in the residents clinical records. it was determined that the policy and procedure were sufficient and required no changes or modifications at this time. in addition all certified nursing assistants received in-service training on 5/11/2023 regarding proper, consistent and completed documentation of residents Activities of Daily living and care provided to the residents medical record in the documentation survey report/ADL Task tab quality Assurance: The Quality Assurance Performance committee shall be responsible for ascertaining the effectiveness of the corrective actions and preventative measures. Nursing Administration shall review the Dashboard and documentation survey report daily of a period of 30 days then weekly for a period of 2 months to determine the level of compliance with the facility charting and documentation requirements in the residents medical records. upon the completion of the three month review the QAPI committee shall review on quarterly basis, the consistent documentation and completion of activities if daily living and care provided to the resident according to facility policy and procedure	

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F 842	Continued From page 7	F 842		

A Care Plan (CP), initiated on 2/24/23 included that the Resident had EX Order 26 § 4b1 [redacted]

7:00 am-3:00 pm shift on 4/1/23 to 4/5/23, 4/14/23 to 4/16/23, 4/18/23 to 4/22/23, and 4/25/23 to 4/30/23, 5/1/23, 5/2/23, 5/5/23, and 5/6/23,
3:00 pm-11:00 pm shift on 4/3/23 to 4/9/23, 4/17/23 to 4/20/23, and 4/25/23 to 4/30/23, 5/1/23 to 5/6/23.
11:00 pm-7:00 am shift on 4/4/23 to 4/8/23, and 4/24/23 to 4/30/23, 5/1/23 to 5/3/23.

During an interview with the surveyor on 5/10/23 at 11:53 am, Licensed Practical Nurse (LPN #1) stated that the Certified Nursing Assistants (CNAs) were expected to document ADL care provided to the resident by the end of the shift in the DSR. She explained that Assistant Director of Nursing (ADON) were to check the documentation to ensure that the DSR is completed at the end of the shift. LPN #1 could not explain why there were blanks in the resident's DSR but stated that they should have been completed to show that the care was/was not provided from the CNAs.

During an interview with the surveyor on 5/10/23 at 2:48 pm, CNA #1 stated that CNAs are responsible for documenting the ADL care provided into the Point of Care (POC), is a mobile-enabled app that runs on wall-mounted kiosks or mobile devices that enables care staff to document activities of daily living at or near the point of care to help improve accuracy and

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F 842	Continued From page 8	F 842		

timeliness of documentation. CNA #1 further stated that they would document even if the care was not provided due to refusal. She explained that the documentation must be completed in the resident's DSR by the end of each shift to show that the care was provided to the residents. CNA #1 could not explain why there were blanks in the sampled resident's DSR.

During an interview with the surveyor on 5/10/23 at 1:54 pm, the Director of Nursing (DON) and ADON stated that the CNAs were expected to document the care provided to the residents in the DSR at the end of the shift. However, the DSR was new to the CNAs and the facility was in the middle to adapting the new system that started in 2/2023.

NJAC 8:39-35.2(d)(9)

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315375	A. Building B. Wing	7/20/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 07/18/2023	ID Prefix F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 07/18/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 5/10/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			