STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315516	A. BUILDING _____ B. WING _____	09/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANCED SUBACUTE REHABILITATION CENTER AT SEWELL	685 SALINA ROAD SEWELL, NJ 08080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: NJ 903 Based on interview, record review and review of other documents provided by the facility, it was determined that the facility failed to notify a resident representative and physician of a significant significant weight loss. This deficient practice occurred for 1 of 1 resident, (closed record of Resident #4) reviewed for notification and was evidenced by the following: According to the Admission Record, Resident #4 was admitted to the facility in June of 2017 and had [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (an assessment tool) dated 03/30/20, revealed that Resident #4 had impaired cognition that included both short-term and long-term memory problems. Further review of the assessment indicated that the resident required extensive assistance of two persons for transfers and required limited assistance of one person for eating. Review of a Physician Note (late entry) dated 04/23/30 at 8:55 PM, revealed that Resident #4 received a telemedicine visit from the Nurse Practioner (NP) who documented that the resident's current weight of 129.1 lbs was stable and the resident had unchanged intake and received an increased amount of health shake supplement drinks according to a chart review. The NP noted that she would appreciate input from the dietician. Review of a Weight Summary revealed that Resident #4 was weighed on 03/25/20 and weighed 129.1 lbs (pounds) by wheelchair. Further review of the document revealed that on 04/30/20 the Dietician entered a sitting weight for the resident which indicated that the resident weighed 120.4 lbs. Review of a Nutrition/Dietary Note dated 05/01/20 at 8:45 AM, revealed that Resident #4 had significant weight loss of 6.7% in one month from 129.1 lbs on 03/25/20 to 120.4 lbs on 04/30/20. The Dietitician documented that the resident utilized adaptive equipment which included: scoop dish, foam utensils and a sip cup to eat and the resident's food intake was between 50-100% according to the record. The resident was ordered 4 ounce health shakes (supplements) three times daily of which the resident consumed 100%. The Dietician noted that Resident #4's weight loss may have been related to a lack of initiation to eat, aging and progression of disease. She also documented that the resident's BMI (body mass index) was 19.4 and weight gain or weight maintenance was desirable. The Dietician recommended that resident be assisted with meals as needed and encouraged oral intake, which included supplement and fluid intake to maximize nutrition. Further review of the Nutrition/Dietary Note indicated that the Dietician added fortified food with meals, encourage resident to eat snacks between meals, house shakes three times daily, monitor oral intake, weight trends and labs as available. Further review of the medical record revealed that there were no additional weights recorded for the resident. On 09/11/20 at at 11:15 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that she worked for an outside agency and was not familiar with Resident #4. She further stated that nursing informed her if she were required to provide feeding assistance to residents when she received her assignment at the start of each shift. The CNA stated that she was required to document the percentage of each meal that the residents consumed in the computer post meals and report any changes in food intake verbally to nursing. The CNA further stated that she was also responsible to obtain resident weights and provided them to nursing for review. At 11:25 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) #1 who stated that the CNA's were responsible to document resident meal consumption. She stated that if the resident consumed less than 25% of meals that it triggered on the dashboard. She stated that the Unit Manger (UM) was responsible to monitor the documentation and resident weights. She further stated that the previous UM no longer worked at the facility and a new acting UM recently transitioned into the position. At 1:00 PM, the surveyor interviewed the Dietician who stated that Resident #4's last recorded weight on 04/30/20 was 120.4 lbs and the prior weight on 03/25/20 was 129.1 lbs. She stated that the weight loss may have been due to a lack of the resident's initiation to eat and progression of Dementia. The Dietician recommended for staff to assist the resident and feed the resident if the resident needed help. The Dietician stated that nursing was responsible to inform the family and physician of Resident #4's weight loss. She stated that the resident's weight loss that was identified on 04/30/20 was significant and the resident should have been re-weighed to confirm accuracy according to the policy. The Dietician stated that if the resident were too sick, it would be too challenging to obtain a weight. The Dietician noted the Resident #4's weight was stable in March but the resident had an 8.7 lb weight loss in April. She stated that ordinarily we would obtain weekly weights to monitor the weight loss progression. The Dietician stated that the resident was declining and that's probably why the weights weren't obtained thereafter. She stated that sometimes she informed the resident's family of the resident's weight loss but she didn't have documentation to support that she did that. She stated that maybe she did it but didn't' document it, as she couldn't' remember as it was chaotic here during that time related to COVID. At 1:32 PM, the surveyor interviewed the Director of Nursing (DON) who stated that she obtained the position in the first week of May and noted that weekly weight meetings were held on Friday. She further stated that due to the COVID Outbreak there were no meetings held at the end of April through July. She stated that the facility reinstituted the meetings. The DON stated that the restorative aide obtained eights and provided them to nursing or the dietician. She stated that that the weights were reviewed and sometimes they got a re-weigh. She stated that a re-weigh would probably be required for an weight loss of 8.7 lbs, but she was unsure of the policy requirement. The DON stated that the dietician would provide the UM with a weight that concerned her but the UM no longer worked at the facility to confirm this. She stated that the facility would typically notify the family and physician of the change of condition but there were many staff out ill during that time. The DON stated that the Progress Notes were reviewed between April and May and there was no documented evidence that the facility notified the family or the doctor of the resident's weight loss that reflected a change in the resident's condition. The surveyor reviewed the facility policy, Change in a Resident's Condition or Status (Revised September 2005), which revealed the following: Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care .). Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. The nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Review of the facility policy, Weight Monitoring (08/15/14), reviewed the following: It is the policy of this facility to monitor for a resident's weight to ensure that he/she maintains his/her weight within acceptable parameters. If there is a weight discrepancy (5 lbs or more gain/loss in 30 days, or 5% in 30 days or 10% in 180 days gain/loss, or 7.5% loss in 90 days, or a 3 lbs loss if resident weighs <100) re-weigh will be done. The weight should be witnessed by the nurse for verification. In the event of verified weight loss/gain, the Dietician will be notified via the Dietary Alert Sheet. The MD and responsible party will also be notified. NJAC 8:39-13.1(c)
F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: NJ 0 Based on observation, interview, record review and other documents provided by the facility, it was determined that the facility failed to develop, implement and document an effective discharge plan to ensure a safe and

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

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F 0660 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) effective transition of care for 1 of 1 residents reviewed for discharge planning, (Resident # 5). This deficient practice was evidenced by the following: The surveyor reviewed the Admission Record of Resident #5 which revealed that the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Admission Record listed the resident (self) as his/her primary responsible party under the contact portion of the document. A review of Resident #5's Admission Minimum Data Set (MDS) (an assessment tool) dated 12/19/19, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 04 which indicated that the resident was severely cognitively impaired. The Functional Status portion of the assessment specified that the resident required limited assistance of one person to transfer and ambulate with a walker or wheelchair. Additional active [DIAGNOSES REDACTED]. The surveyor reviewed a Physician Note dated 01/17/20 at 10:00 PM which indicated that Resident #5 was admitted to the facility for rehabilitation for overall de-conditioning. Further review of the note revealed that the resident was anxious and had an altered mental status and agitation. The Physician noted that the resident had an altered mental status with agitation and anxiously wanted to go home. The surveyor reviewed a Skilled Note contained within the Progress Notes (PN) that was written by Licensed Practical Nurse (LPN) #1 on 01/18/20 at 6:41 PM, which documented that Resident #5 was awake, alert and was only oriented to self. The LPN documented that she applied a Wander Prevention Device (a device that is worn that signals when one nears an exit) to the resident's right leg to assure resident safety. The surveyor reviewed a Social Services Note (SSN) dated 01/28/20 at 10:11 AM, which documented that the facility Social Worker (SW) #1 phoned the apartment complex where Resident #5 resided prior to admission and spoke with the Building Manager who informed SW #1 that the apartment was available but she did have concerns related to Resident #5's cognition. Review of an SSN dated 01/30/20 at 3:41 PM, revealed that SW #1 placed a call to Adult Protective Services (APS) regarding Resident #5's discharge and SW #1 explained that the resident wanted to return home with Visiting Nursing Services to follow initially. The SW Note specified that a call was placed to Resident Representative #2, Who did not really want to deal with Resident #5. The SW documented that the Resident Representative #1 caregiver (sic.) was informed of discharge. The surveyor reviewed a Social Services note dated 01/30/20 at 3:47 PM, in which the SW documented that upon speaking with Adult Protective Services calls were placed to the Apartment Building Manager to advise of Resident #5's discharge. The surveyor reviewed a Progress Note written by LPN #2 on 01/30/20 at 8:10 PM, which detailed that Resident #5's Wander Prevention Device was taken off when the resident was discharged home. LPN #2 further stated that SW #1 had advised her of the pending discharge and Resident #5 left at 8:10 PM with instructions. LPN #2 documented that the resident was transported back to the facility at 10:00 PM because a family member was not at home. LPN #2 noted that the Wander Prevention Device was intact on the resident's right ankle. Further review of the Progress Note revealed an entry dated 01/31/20 at 1:15 PM written by LPN #3, which indicated that Resident #5 was discharged on this date with transportation to home. LPN #3 noted that the resident received all discharge paperwork and resident representative #2 was made aware. Further review of the PN revealed that on 01/31/20 at 4:33 PM, the Care Manager/Coordinator (CM/C), documented that the resident was returned to the building. The CM/C also documented that a Wander Prevention Device was placed on the resident's left leg. On 09/11/20 at 11:25 AM, during the initial tour of building, the Assistant Director of Nursing (ADON) #1 informed the surveyor that the CM/C no longer worked for the facility and was not available for interview. At 11:45 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) #1 on the Memory Care Unit (locked unit) who identified Resident #5 and described the resident as calm and wore a Wander Prevention Device. At 11:52 AM, the surveyor observed Resident #5 seated in a chair in the hallway. The resident was pleasant when approached and invited the surveyor into his/her room. When interviewed, the resident stated that he/she had no recollection of being discharged from the facility and could not recall ever having lived in the town that the facility attempted to discharge the resident to previously. The resident stated that he/she had a mentally disabled adult child who was his/her only family contact as he/she was estranged from any remaining family. At 12:02 PM, the surveyor interviewed LPN #4 who stated that Resident #5 was admitted to the Memory Care Unit in November or December of 2019 and the resident had an adult child who resided in a Group Home. LPN #4 reviewed the resident's Admission Record on the computer in the presence of the surveyor and stated that the Resident was listed as his/her own representative and the resident's mentally disabled child was listed as the first Resident Representative. LPN #4 stated that Resident #5 was determined to be unable to care for himself/herself at home. She further stated that the facility Social Worker #1 recently passed away. At 12:14 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that Resident #5 was admitted to the Memory Care Unit under Guardianship (under the care of someone who was unable to manage their own affairs) as the resident only had a disabled child who resided in a group home. The RN/UM stated that SW #1 informed her that the resident was unable to return to his/her apartment as it was no longer available. At 12:34 PM, the surveyor interviewed Social Worker #2 who stated that when a resident was admitted to the facility the Social Worker was responsible to validate the accuracy of the BIMS Score and if the resident was deemed to be confused a responsible party must participate in the discharge planning process. He stated that if there were no responsible party then SW would have to involve Adult Protective Services and the Ombudsman to help secure placement and figure out custodial care. The SW stated that if he had a resident with a BIMS Score of 04 he would involve the Administrator and Admissions for placement of the resident as the last thing that he would want was to send someone home who was unsafe. He further stated that it would be unsafe to send someone home alone with visiting nursing who had a BIMS Score of 04. At 2:19 PM, the surveyor conducted a telephone interview with LPN # 2 who stated that she recalled that Resident #5 was discharged and returned to the facility the same evening because transport was unable to reach anyone at the resident's home. She further stated that the resident was unable to live independently and there was no family involvement as the family did not pick up calls from the facility. At 2:31 PM, the surveyor interviewed the Administrator who stated that Resident #5's Resident Representative #2 did the resident's food shopping and she was under the impression that RR #2 would be at the resident's apartment to receive the resident upon return the apartment. The Administrator further stated that the resident was supposed to be discharge home with visiting nursing services. She stated that it wasn't a safe plan for the resident who had a BIMS Score of 04 to return to his/her apartment alone in the care of someone who was only available to assist with food shopping. The Administrator stated that the facility-initiated Guardianship for Resident #5 and the resident was placed on the Memory Care Unit. She further stated that two physician's and a psychiatrist were required to deem the resident incompetent. The Administrator stated that if the SW reached out to Adult Protective Services it indicated that there was a problem. The Administrator stated that the resident's representatives wouldn't return phone calls and did not provide insight into the resident's living situation. She stated that we probably should have kept the resident here until we reached the family to ensure that they were willing to accept the resident because the resident required 24-hour supervision and assistance. She further stated that we shouldn't have discharged the resident. Guardianship should have been secured beforehand instead of after the fact. The surveyor reviewed the facility policy, Discharge Planning (Effective 08/15/14), which revealed the following: Discharge potential for all residents admitted at Advanced Subacute Rehabilitation Center will be evaluated during care planning conferences. Information from the resident, family and all involved disciplines will identify candidates for discharge to a lower level of care, less intensive care setting, or to home. NJAC 8:39-5.4(a)(b)(c)