STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315122	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTFIELD CENTER	**1515 LAMBERTS MILL ROAD WESTFIELD, NJ 07090**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** COMPLAINT # NJ 9, NJ 0 Based on interviews, review of Medical Records (MR), and other pertinent facility documentation on 3/4/2020 and 3/5/2020, it was determined that the facility staff failed to maintain accurate MR for documentation of resident ADLs to show that the task was completed and failed to follow the Facility Policy titled Nursing Documentation, for 2 of 7 sampled residents (Resident #1 and Resident #3). This deficient practice was evidenced by the following: 1. According to the Admission Record (AR), Resident #1 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS), an assessment tool dated 9/23/2019, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 6/15, indicating Resident #1 had severe cognitive impairment. The MDS also showed the resident required total assistance for Activities of Daily Living (ADLs). Review of the Care Plan (CP) for Resident #1 with an initiated date of 12/23/2019, included the following problem: Resident requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: Paralysis/Weakness and status [REDACTED]. Review of Resident #1's MR titled Documentation Survey Report V2 dated February 2020, which is documentation by the Certified Nursing Assistant (CNA) for completion of ADLs, under Intervention/Task Bathing did not include documentation that bathing was done for the following days: 2/1, 2/2, 2/3, 2/8, 2/9, 2/10, 2/11, 2/12, 2/13, 2/14, 2/15, 2/16, 2/17, 2/18, 2/19, 2/21, 2/22, 2/23, and 2/24, 2/25, and 2/27/20. 2. According to the AR, Resident #3 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. According to the MDS, an assessment tool dated 11/9/2019, Resident #3 had a BIMS score of 3/15, indicating Resident #3 had severe cognitive impairment. The MDS also showed the resident required extensive assistance for ADLs. Review of the CP for Resident #3 with an initiated date of 9/12/2019, included the following problem: Resident requires assistance, extensive to total care, for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: Chronic disease/condition. Interventions included but were not limited to; total assist of 2 for all care. Review of Resident #3's MR titled Documentation Survey Report V2 dated February 2020, for completion of ADLs, under Intervention/Task Bathing did not include documentation that bathing was done for the following days: 2/1, 2/2, 2/7, 2/8, 2/9, 2/11, 2/14, 2/15, 2/16, 2/17, 2/21, 2/22, 2/23, and 2/25/2020. During an interview on 3/4/2020 at 1:48 p.m., CNA #1 reported washing, brushing teeth, hair combing and changing their clothes is all part of daily care. In addition, the CNA reported documentation is part of the CNA's responsibility. During an interview on 3/5/2020 at 11:40 a.m., the Director of Nursing (DON) reported, the CNA may have forgotten to document on those days in February or the residents may have refused care, however, the DON reported that there was no documentation to show the residents refused care on those days in February. Review of the Facility Policy titled Nursing Documentation with an effective date of 08/01/05, and a revision date of 11/01/19, revealed the following under Policy: Nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent, and accurate Under Purpose: To communicate patient's status and provide accurate accounting of care and monitoring provided. NJAC 8:39-35.2(d)(9)

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

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.