

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315174	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/22/2024
NAME OF PROVIDER OR SUPPLIER  Deptford Center for Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1511 Clements Bridge Rd Deptford, NJ 08096	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 18947</p> <p>C# NJ166810 C# NJ167847 C# NJ168096</p> <p>Based on interview, document review, and review of facility policy, the facility failed to ensure four residents (Resident (R) 6, R9, R25, and R30) of 31 sampled residents reviewed for abuse were free from resident-to-resident abuse perpetrated by R5. This had the potential to affect resident safety at the facility.</p> <p>Findings include:</p> <p>Review of R5's electronic medical record (EMR) titled Admission Record located under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses including schizophrenia and Alzheimer's disease.</p> <p>Review of R5's EMR titled Care Plan located under the Care Plan tab, dated 05/07/24, indicated the resident had a history of behaviors such as making false accusations of assault or missing money, yelling at staff and residents, cursing, and aggression toward other residents.</p> <p>Review of R5's EMR annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/03/24 and located under the MDS tab, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which revealed the resident was cognitively intact. The assessment indicated the resident did not exhibit any behaviors during the assessment reference period.</p> <p>1. Review of R6's electronic medical record (EMR) titled Admission Record located under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses including lung cancer and dementia.</p> <p>Review of R6's EMR titled Care Plan located under the Care Plan tab, dated 06/08/23, indicated the resident had a history of behaviors such as using racial slurs, wandering, and cursing at residents. The care plan indicated R6 had severe memory impairment due to her diagnosis of dementia. The care plan indicated the resident was at high risk for experiencing abuse.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of R6's EMR annual MDS with an ARD of 05/12/24 and located under the MDS tab, indicated the resident had a BIMS score of six out of 15 which indicated the resident was severely cognitively impaired. The assessment indicated the resident did not exhibit any behaviors during the assessment reference period.</p> <p>Review of R5's Progress Notes, dated 08/14/23 and located in the EMR under the Progress Notes tab, revealed the resident was involved in a witnessed event during which the resident argued with R6 in the hallway, was separated from R6, and then ran back down the hallway toward R6 and hit R6 on her left shoulder three times.</p> <p>Review of a document provided by the facility titled Investigation Report, dated 08/16/23, indicated R5 and R6 were immediately separated, and an investigation was initiated related to the alleged abuse. The record indicated no injury to either resident related to the incident. The investigation findings indicated abuse could not be substantiated due to the event was not predictable and was an isolated event. The documentation read, in pertinent part, Any reasonable person would conclude the event was unavoidable due to residents psychiatric diagnosis in conjunction with presenting behaviors.</p> <p>2. Review of R9's EMR titled Admission Record located under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses including schizophrenia and depression.</p> <p>Review of R9's EMR titled Care Plan located under the Care Plan tab, dated 10/04/23, indicated the resident had a history of experiencing hallucinations and delusions. The care plan indicated R9 was at high risk for experiencing abuse.</p> <p>Review of R9's quarterly MDS with an ARD of 05/11/24 and located in the EMR under the MDS tab, indicated the resident had a BIMS score of 14 out of 15 which indicated the resident was cognitively intact. The assessment indicated the resident experienced delusions during the assessment reference period.</p> <p>Review of R5's Progress Notes located in the EMR under the Progress Notes tab, indicated a second event, dated 09/09/23 during which R9 reported R5 entered her room and punched her on her left leg. The record indicated R5 stated she punched R9 on the leg because she thought someone had taken her money.</p> <p>Review of a document provided by the facility titled Investigation Report, dated 09/10/23, indicated R5 and R9 were immediately separated, and an investigation was initiated related to the alleged abuse. The record indicated no injury to either resident related to the incident. The investigation findings indicated abuse could not be substantiated due to the event was not predictable and was an isolated event. The documentation read, in pertinent part, Any reasonable person would conclude the event was unavoidable due to residents psychiatric diagnosis with presenting behaviors in conjunction with diagnosis of chronic UTIs (urinary tract infections). This was an isolated event.</p> <p>3. Review of R25's EMR titled Admission Record located under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia with behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of R25's EMR titled Care Plan located under the Care Plan tab, dated 11/03/20, indicated the resident was severely cognitively impaired and had a history of exhibiting behaviors such as verbal and physical aggression toward other residents. The care plan indicated R25 was at high risk for experiencing abuse.</p> <p>Review of R25's quarterly MDS with an ARD of 04/01/24 and located in the EMR under the MDS tab, indicated the resident had a BIMS score of 99 (the assessment was not able to be completed due to the resident's poor cognition). The assessment indicated the resident did not exhibit any behaviors during the assessment reference period.</p> <p>Review of R5's Progress Notes located in the EMR under the Progress Notes tab, indicated a third event, dated 08/19/23 during which R5 was witnessed by staff charging at R25 and repeatedly stabbing him/her with an ink pen, causing two small skin tears on R25's right forearm.</p> <p>Review of a document provided by the facility titled Investigation Report, dated 08/21/23, indicated R5 and R25 were immediately separated, and an investigation was initiated related to the alleged abuse. R25 was treated for his/her skin wounds. The investigation findings indicated abuse could not be substantiated due to the event was not predictable and was an isolated event. The documentation read, in pertinent part, Any reasonable person would conclude the event was unavoidable due to residents psychiatric diagnosis in conjunction with diagnosis of UTI.</p> <p>4. Review of R30's EMR titled Admission Record located under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia with behaviors.</p> <p>Review of R30's EMR titled Care Plan located under the Care Plan tab, dated 01/06/21, indicated the resident was severely cognitively impaired and had a history of exhibiting behaviors such as yelling out, banging on doors, and raising her fist and yelling at staff. The care plan indicated R30 was at high risk for experiencing abuse.</p> <p>Review of R30's quarterly MDS with an ARD of 04/29/24 and located in the EMR under the MDS tab, indicated the resident had a BIMS score of three out of 15, which revealed the resident was severely cognitively impaired. The assessment indicated the resident did not exhibit any behaviors during the assessment reference period.</p> <p>Review of R5's Progress Notes located in the EMR under the Progress Notes tab, indicated a fourth event, dated 09/01/23 during which R5 was witnessed by staff standing over R30, screaming, and cussing and grabbing his/her arm. The documentation indicated R30 was yelling out [R5]'s hurting me! The documentation indicated R30 sustained a superficial scratch to his/her right arm related to the incident.</p> <p>Review of a document provided by the facility titled Investigation Report, dated 09/02/23, indicated R5 and R30 were immediately separated, and an investigation was initiated related to the alleged abuse. R30 was treated for her skin wound. The investigation findings indicated abuse could not be substantiated due to the event was not predictable and was an isolated event. The documentation read, in pertinent part, Any reasonable person would conclude the event was unavoidable due to residents psychiatric diagnosis with presenting behaviors in conjunction with diagnosis of chronic UTIs.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's Accident/Incident Log and Reportable Events Log, both dated 05/01/23 through 05/20/24, revealed four separate incidents between R5 and different residents during which R5 exhibited abusive behavior to these residents. All the incidents occurred between 08/14/23 and 09/09/23. No further incidents were documented in either of the logs after 09/09/23 related to R5 and resident to resident abuse.</p> <p>Continued review of R5's record indicated no additional incidents of potential resident to resident abuse involving the resident. The record indicated the last incident of potential resident to resident abuse related to R5 occurred on 09/09/23. The record indicated interventions, such as increased supervision of R5 and moving R5 into a private room immediately across from the nurse's station, had been implemented since 09/09/23 to prevent further incidents.</p> <p>During an interview on 05/22/24 at 10:30 AM, Unit Manager (UM) 1 indicated she was very familiar with R5 and confirmed R5 had been the instigator in multiple resident-to-resident incidents of abuse during the summer/fall of 2023. She confirmed interventions had been put into place since that time and stated she was not aware of any recent incidents of alleged abuse involving R5. She stated, We have eyes on [R5] at all times. [R5] did have quite a few resident to resident (altercations). [R5] is better now. [R5] seems a little more calm in a private room and we keep [R5] away from other residents, which is his/her preference anyway. We have not had any resident to resident for a while now with [R5]. UM 1 stated R5 getting physical with other residents should be considered abuse.</p> <p>During an interview on 05/22/24 at 10:40 AM, Certified Nursing Assistant (CNA) 13 confirmed she was familiar with R5 and confirmed R5 had a history of resident-to-resident incidents of abuse in the past. CNA13 stated she had not seen any physical altercations between R5 and other residents in a while. CNA13 stated, [R5] is close (to the nurse's station) and in our line of site now, so we can intervene with him/her before anything even happens. I know [R5] and how to intervene.</p> <p>During an interview on 05/22/24 at 10:45 AM, CNA14 confirmed she was familiar with R5 and stated R5 had been involved in multiple resident-to-resident physical altercations in the past but stated she had not witnessed any recent events involving R5 and other residents.</p> <p>During an interview on 05/22/24 at 10:50 AM, Licensed Practical Nurse (LPN) 8 confirmed she was familiar with R5 and stated the resident had been involved in quite a few resident to resident physical altercations in the past, but she had not witnessed anything recently. She stated, We do what we need to calm [R5] down. I cannot pinpoint any physical altercations recently. But [R5] has had in the past. At one point in time there were quite a few .[R5] has a private room now because we couldn't take a chance with roommates, [R5] stays in his/her favorite spot, and [R5] writes notes with his/her pen and a book.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/22/24 at 11:55 AM, the Director of Nursing (DON) stated the facility's Administrator was the Abuse Coordinator, however she was responsible for ensuring investigations into allegations were completed and completing the investigation findings report based on the investigation results. The DON stated R5 had frequent urinary tract infections, and because of her diagnosis of recurrent UTI's, abuse had not been substantiated for any of the above referenced incidents of resident-to-resident physical abuse. The DON further stated her understanding was if staff had not done anything to purposefully instigate resident to resident abuse between residents, abuse could not be substantiated. She stated, I did not understand that resident to resident abuse was a thing. I was referencing staff in all (of the investigations) and saying that the staff did not coerce any resident to be abusive (and so no abuse occurred).</p> <p>During an interview on 05/22/24 at 12:30 PM, the Administrator stated his expectation was any resident altercation during which there was an intent to do harm to another person should be considered abuse.</p> <p>Review of the facility's policy titled, Abuse, dated 12/22 and provided by the facility, indicated The facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone including but not limited to staff, family, friends and residents of the facility; and Physical Abuse: includes hitting, slapping, pinching, scratching, spitting, holding roughly, kicking, etc. It also includes controlling behavior through corporal punishment.</p> <p>NJAC 8:39-4.1(a)5</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 03115</p> <p>12679</p> <p>C# NJ165261 C#NJ165932 C#NJ166156 C#NJ166810 C#NJ167718 C#167847 C#NJ168096 C#NJ168350 C#NJ168593 C#NJ171428</p> <p>Based on interview, document review, and review of facility policy, the facility failed to ensure the facility reported the results of their abuse/neglect investigations to the State Survey Agency (SSA) within five working days for 10 out of 13 residents (Resident (R) 3, R4, R5, R6, R9, R2, R11, R7, R31, R14) reviewed for abuse of 31 sampled residents. This failure had the potential to delay corrective measures and appropriate response to abuse allegations ensuring the safety of the residents.</p> <p>Findings include:</p> <p>1. Review of R3's electronic medical record (EMR) titled Admission Record located under the Profile tab revealed the resident was admitted to the facility on [DATE] with a diagnosis of vascular dementia.</p> <p>Review of R3's EMR titled Care Plan located under the Care Plan tab, dated 02/19/18, indicated the resident had a history of behaviors such as screaming and cursing at staff. The Care Plan revealed the resident had a history of confabulation (false memory creation).</p> <p>Review of R3's EMR significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/11/23 and located under the MDS tab, indicated the resident had a Brief Interview for Mental Status (BIMS) score of nine out of 15 which revealed the resident was moderately cognitively impaired. The assessment indicated the resident made verbal threats, such as screaming and threatening others.</p> <p>Review of R3's EMR titled Registered Nurse [RN] Assessment, dated 07/10/23 and located under the Progress Notes tab, indicated the resident informed staff that a Licensed Practical Nurse (LPN) 4 choked her.</p> <p>Review of a document provided by the facility titled Investigation Report, dated 07/12/23, indicated LPN4 was immediately suspended pending the outcome of the investigation. There was evidence which showed the facility reported the initial allegation made by R3 to the SSA within two hours. There was no evidence in the investigative file which showed the results of the facility's investigation were submitted within five business days to the SSA. No abuse was substantiated, and LPN4 returned to the facility.</p> <p>2. Review of R4's EMR titled Admission Record located under the Profile tab indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of left sided stroke.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a document provided by the facility titled Investigation Report, dated 07/05/23, indicated a family member reported on 07/03/23 that Certified Nursing Assistant (CNA) 3 was rough while providing R4 care while working on the 11:00 PM to 7:00 AM shift. The investigation revealed CNA3 was immediately suspended pending the outcome of the investigation. There was evidence which showed the facility reported the initial allegation made by R4's family member to the SSA within two hours. There was no evidence in the investigative file which showed the results of the facility's investigation were submitted within five business days to the SSA. No abuse was substantiated, and CNA3 returned to the facility.</p> <p>There were no clinical records which mentioned the allegations made by R4's family member on 07/03/23.</p> <p>Review of R4's EMR titled Care Plan located under the Care Plan tab, dated 08/02/23, indicated the resident had behaviors such as crying out loud and was accusatory.</p> <p>Review of R4's EMR titled admission MDS with an ARD of 12/12/23 and located under the MDS tab, indicated the resident had a BIMS score of 15 out of 15 which revealed the resident was cognitively intact. The assessment revealed the resident had no behavioral concerns.</p> <p>Review of R4's EMR titled Nursing Clinical Evaluation, dated 01/15/24 and located under the Progress Notes tab, indicated the family member of the resident reported that the resident was afraid of CNA4 since the staff member allegedly spoke rudely to her and removed the call light from the resident.</p> <p>Review of a document provided by the facility titled Investigation Report, dated 01/23/24, indicated a family member reported on 01/15/24 that on 01/14/24, during the 11:00 PM to 7:00 AM shift, CNA4 spoke with R4 in an inappropriate manner and then took the resident's call light from her. The investigation revealed CNA4 was immediately suspended pending the outcome of the investigation. There was evidence which showed the facility reported the initial allegation made by R4's family member to the SSA within two hours. There was no evidence in the investigative file which showed the results of the facility's investigation were submitted within five business days to the SSA. No abuse was substantiated, and CNA4 returned to the facility.</p> <p>During an interview on 05/21/24 at 9:28 AM, the Director of Nursing (DON) stated she reported allegations of abuse to the SSA within two hours. The DON stated she submitted the five-day results of her investigations to the SSA by email but had no evidence to show that the five-day reports were submitted to the SSA.</p> <p>3. Review of R5's EMR titled Admission Record located under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses including schizophrenia and Alzheimer's disease.</p> <p>Review of R5's EMR titled Care Plan located under the Care Plan tab, dated 05/07/24, indicated the resident had a history of behaviors such as making false accusations of assault or missing money, yelling at staff and residents, cursing, and aggression toward other residents.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of R5's EMR annual MDS with an ARD of 03/03/24 and located under the MDS tab, indicated the resident had a BIMS score of 13 out of 15 which indicated the resident was cognitively intact. The assessment indicated the resident did not exhibit any behaviors during the assessment reference period.</p> <p>4. Review of R6's EMR titled Admission Record located under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses including lung cancer and dementia.</p> <p>Review of R6's EMR titled Care Plan located under the Care Plan tab, dated 06/08/23, indicated the resident had a history of behaviors such as using racial slurs, wandering, and cursing at residents. The care plan indicated R6 had severe memory impairment due to her diagnosis of dementia. The care plan indicated the resident was at high risk for experiencing abuse.</p> <p>Review of R6's EMR annual MDS with an ARD of 05/12/24 and located under the MDS tab, indicated the resident had a BIMS score of six out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated the resident did not exhibit any behaviors during the assessment reference period.</p> <p>Review of R5's Progress Notes, dated 08/14/23 and located in the EMR under the Progress Notes tab, revealed the resident was involved in a witnessed event during which the resident argued with R6 in the hallway, was separated from R6, and then ran back down the hallway toward R6 and hit R6 on her left shoulder three times.</p> <p>Review of a document provided by the facility titled Investigation Report, dated 08/16/23, indicated R5 and R6 were immediately separated, and an investigation was initiated related to the alleged abuse. The record indicated no injury to either resident related to the incident. There was evidence which showed the facility reported the initial allegation of physical abuse of R6 by R5 timely, however there was no evidence in the investigative file to show the results of the facility's investigation were submitted within five business days to the SSA.</p> <p>5. Review of R9's EMR titled Admission Record located under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses including schizophrenia and depression.</p> <p>Review of R9's EMR titled Care Plan located under the Care Plan tab, dated 10/04/23, indicated the resident had a history of experiencing hallucinations and delusions. The care plan indicated R9 was at high risk for experiencing abuse.</p> <p>Review of R9's quarterly MDS with an ARD of 05/11/24 and located in the EMR under the MDS tab, indicated the resident had a BIMS score of 14 out of 15 which revealed the resident was cognitively intact. The assessment indicated the resident experienced delusions during the assessment reference period.</p> <p>Review of R5's Progress Notes located in the EMR under the Progress Notes tab, indicated a second event, dated 09/09/23 during which R9 reported R5 entered her room and punched her on her left leg. The record indicated R5 stated she punched R9 on the leg because she thought someone had taken her money.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a document provided by the facility titled Investigation Report, dated 09/10/23, indicated R5 and R9 were immediately separated, and an investigation was initiated related to the alleged abuse. The record indicated no injury to either resident related to the incident. There was evidence which showed the facility reported the initial allegation of physical abuse of R9 by R5 timely, however there was no evidence in the investigative file to show the results of the facility's investigation were submitted within five business days to the SSA.</p> <p>6. Review of R2's Admission Record from the EMR Profile tab showed a facility admitted [DATE] with medical diagnoses that included encephalopathy, pancytopenia, cerebral infarction, traumatic subdural hematoma, and seizures.</p> <p>Review of the Progress Notes from the EMR Progress Notes tab, showed on 06/21/23 at 10:36 PM, R2 had a fall at 8:40 PM with bleeding from the mouth and a dislodged tooth due to hitting her head on the floor. R2 was sent to the emergency room and admitted with subdural hematoma.</p> <p>Review of the facility provided investigation report to the State Agency revealed the top sheet of the Reportable Event Record/Report [aka AAS45] showed the date of event was 06/22/23 at 2:00 PM and today's date was documented as 06/24/23. The Investigation Form revealed On 06/21/23 resident [R2's name] was observed walking towards nursing station of unit 2b and falling on the floor. The last page in the file showed R2's representative was notified of the fall on 06/21/23 at 8:44 PM. Further review of the investigation file showed no evidence that the completed five-day investigation was provided to the State Agency.</p> <p>7. Review of R11's Admission Record from the EMR Profile Tab showed a facility admitted [DATE] with medical diagnoses that included asthma, depression, anxiety, dementia, protein calorie malnutrition, cognitive communication deficit, and a language disorder.</p> <p>Review the Progress Notes from the EMR Progress Notes tab, showed on 10/23/23 at 5:05 PM that R11 was experiencing right lower extremity pain following a fall on 10/22/23. The medical practitioner was notified, and an X-ray was ordered.</p> <p>A review of the facility provided Reportable Event Record/Report [aka AAS45] showed the date of event from the top line of the report was 10/24/23 and the Today's Date was 10/25/23. Further review showed the X-ray report of the injury was received on 10/24/23. The investigation file did not show evidence of the completed five-day investigation report being provided to the State Agency.</p> <p>During an interview on 05/22/24 at 11:00 AM, the DON stated .the date of the event on the first page of the AAS45 is when I am first made aware [of the incident]. The date called in on the third page will match the date of the event on the first page, which is when I am made aware and will call it within two hours. When asked if there was any evidence or documentation that the completed five-day investigation was provided to the State Agency, the DON explained that the company deleted emails after 30 days, but she would contact the corporate office to see if there was any way of retrieving emails. At 11:45 AM, the DON stated the regional office advised her there was no way to retrieve the emails. At 12:07 PM, the DON confirmed that there was no evidence of the submission of the final investigation reports to the state agency.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315174	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/22/2024
NAME OF PROVIDER OR SUPPLIER  Deptford Center for Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  1511 Clements Bridge Rd Deptford, NJ 08096	
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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/22/24 at 12:49 PM regarding the State Agency report investigations, the Administrator stated an expectation that We do reportable, and we do the investigation. As soon as we find something we call it in, within the time frame; the AAS45 is sent in which gives a brief summary and lists interventions. A full investigation is completed and sent [to the State Agency] upon request. The State does not always request a full investigation, but I think [DON's name] sends it in.</p> <p>8. Review of a document titled the New Jersey Department of Health and Senior Services . Division of Health Facilities Evaluation and Licensing .Reportable Event Record/Report, dated 09/11/23 revealed on 09/08/23 at 9:00 AM, R7 reported he was not receiving his breakfast and care prior to dialysis on Tuesday, Thursday, and Saturday. According to this report, the State Agency (SA) was notified of the allegation on 09/08/23 at 10:30 AM.</p> <p>Review of the Investigation Form signed by the Director of Nursing (DON) with a signature date of 09/10/23, revealed the investigation was complete. There was no evidence in the report or in the investigation documentation to show the report was submitted to the SA within five days after the initial report.</p> <p>During an interview on 05/22/24 at 12:51 PM, the DON verified she did not have any evidence to show she submitted the result of the investigation to the SA.</p> <p>9. Review of a document titled the New Jersey Department of Health and Senior Services . Division of Health Facilities Evaluation and Licensing .Reportable Event Record/Report, dated 10/19/23 revealed on 10/16/23 at 3:00 PM, R31 stated a nurse on the 11:00 PM to 7:00 AM shift made a verbally aggressive comment to her. Review of the report revealed the SA was notified of the alleged abuse on 10/16/23 at 4:00 PM, one hour after R31 made the allegation.</p> <p>Review of the Investigation Form signed by the DON with a signature date of 10/18/23, revealed the investigation was complete and the verbal abuse could not be substantiated. The investigation report and its attachments did not show that the results of the investigation were sent to the SA within five days after the allegation was received.</p> <p>During an interview on 05/22/24 at 12:51 PM, the DON verified she did not have any evidence to show she submitted the result of the investigation to the SA.</p> <p>10. Review of the New Jersey Department of Health and Senior Services .Division of Health Facilities Evaluation and Licensing .Reportable Event Record/Report, dated 02/13/24 with an event date of 02/12/24 at 4:00 PM and completed by the DON revealed staff to resident abuse was alleged. According to the report facility staff was made aware on 02/12/24 by the Ombudsman's office that Resident 14's wife alleged R14 was spoken to in an inappropriate manner by a Certified Nursing Assistant. The family member was unable to provide specific dates. The initial report was made to the State Agency on 02/12/24 at 4:19 PM within an hour of finding out about the allegation from the Ombudsman.</p> <p>Review of the Investigation form, signed by the DON with signature date of 02/19/24, revealed the investigation was complete. The investigation report and its attachments lacked evidence to support that the results of the investigation were sent to the SA within five days after the allegation was received.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315174	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/22/2024
NAME OF PROVIDER OR SUPPLIER  Deptford Center for Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  1511 Clements Bridge Rd Deptford, NJ 08096	

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/22/24 at 12:51 PM, the DON verified she did not have any evidence to show she submitted the result of the investigation to the SA.</p> <p>Review of the facility's policy titled, Abuse, dated 12/22 and provided by the facility, indicated .The facility prohibits the mistreatment, neglect, and abuse of residents/patients. which strives to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property .The Administrator and Director of Nursing are responsible for investigation and reporting .Report results of investigation to the proper authorities as required by State law . There was no information in the policy which directed the facility to submit the results of their investigation to the State Survey Agency (SSA) within five business days.</p> <p>NJAC 8:39-9.4(e)</p> <p>18947</p> <p>28154</p>