

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2024
NAME OF PROVIDER OR SUPPLIER Lopatcong Center		STREET ADDRESS, CITY, STATE, ZIP CODE 390 Red School Lane Phillipsburg, NJ 08865	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49509</p> <p>C #: NJ00173585</p> <p>Based on interviews, medical record review, and review of other pertinent facility documents on 6/25/24 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 policies and procedures for 1 of 4 residents (Resident #3) reviewed for documentation. This deficient practice was evidenced by the following:</p> <p>1. According to the Admission Record (AR), Resident #3 was admitted on [DATE], with diagnoses that included but were not limited to: Fracture of Unspecified Part of the Neck of the Right Femur, Parkinson Disease, and History of fall.</p> <p>The Minimum Data Set (MDS), an assessment tool, dated 2/5/24, revealed a Brief Interview of Mental Status (BIMS) of 0 which indicated the resident's cognition was severely impaired and the resident needed assistance with ADLs including toileting, eating, and transfer.</p> <p>A Care Plan (CP), initiated on 1/31/24 included that the Resident was dependent for ADL care.</p> <p>Review of Resident #3's DSR (ADL Record) and the progress notes (PN) for the month of 2/2024 revealed lack of documentation to indicate that the care for toileting, eating, and transfer was provided and/or the resident refused care on the following dates and shifts.</p> <p>Toileting and Transfer:</p> <p>7:00 a.m.-3:00 p.m. shift on 2/2/24, 2/4/24, 2/6/24, 2/9/24, 2/10/24, 2/12/24, 2/13/24, 2/17/24, 2/18/24, and 2/19/24.</p> <p>3:00 p.m.-11:00 p.m. shift on 2/3/24, 2/4/24, 2/5/24, 2/8/24, 2/9/24, 2/10/24, 2/15/24, 2/18/24, and 2/19/24.</p> <p>11:00 p.m.-7:00 a.m. shift on 2/9/24, 2/11/24, 2/14/24, 2/15/24, 2/17/24, and 2/19/24.</p> <p>For Eating:</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/13/24 and 2/17/24 to 2/19/24 at 8:00 am, on 2/2/24, 2/9/24, 2/10/24, 2/13/24, and 2/17/24 to 2/19/24 at 12:00 p.m., and on 2/2/24 to 2/5/24, 2/8/24 to 2/14/24, 2/18/24, and 2/19/24 at 6:00 p.m.</p> <p>During an interview with the surveyors on 6/25/24 at 1:00 p.m., Certified Nursing Assistants (CNA #1), who took care of Resident #3, stated that CNAs are responsible for documenting the ADL care provided into the Point of Care (POC), 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 timeliness of documentation, at the end of the shift.</p> <p>During an interview with the surveyors on 6/25/24 at 1:24 p.m., the Unit Manager/Licensed Practical Nurse (UM/LPN#1), stated that CNAs were responsible for documenting the ADL care provided into the POC. The UM/LPN further stated that the CNAs need to document in the DSR even if the care was not provided due to refusal. She explained that the documentation must be completed in the residents' DSR by the end of each shift to show that the care was provided to the residents.</p> <p>During an interview with the surveyors on 6/25/24 at 2:58 p.m., the Director of Nursing (DON) stated that the CNA's were expected to document ADL care provided to the residents by the end of the shift in the DSR. She explained that Nurses, UMs, and ADON were to check the documentation to ensure that the DSR is completed at the end of the shift. The DON could not explain why there were blanks in the resident's DSR.</p> <p>Review of the facility policy titled Nursing Documentation, revised on 5/1/23, reflected POLICY Nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent, and accurate based on the resident's/patient's .condition, situation, and complexity .Documentation for subsequent and/or routine care and procedures may be completed by exception or the use of a checklist, flow charts, or other documentation tools .Nursing documentation will follow established policies and procedures and federal and state regulations .PRACTICE STANDARDS 1. Documentation of nursing care is recorded in the medical record and is reflective of the care provided by nursing staff .3. Timely entry of documentation must occur as soon as possible after the provision of care and in conformance with time frames for completion as outlined by other policies and procedures .</p> <p>Review of a facility policy titled Activities of Daily Living (ADLS), revised 5/1/23, reflected Based on the comprehensive assessment of a patient and consistent with the patient's needs and choices the Center must provide the necessary care and services to ensure that a patients activities of daily living (ADL) abilities are maintained or improved and to not diminish unless circumstances of the patient's clinical condition demonstrate that a change was unavoidable. Activities of daily living (ADLs) include .Elimination - toileting .5. Documentation of ADL care is recorded in the medical record and is reflective of the care provided by nursing staff. ADL care will be documented in real time, as close to the time that care was provided, and information obtained as possible. ADL care is documented every shift by the nursing assistant. 5.1 The licensed nurse will document ADL care they provided, when applicable .</p> <p>NJAC 8:39-35.2(d)(9)</p>		