

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/28/2025
NAME OF PROVIDER OR SUPPLIER  Phoenix Center for Rehabilitation and Pediatrics		STREET ADDRESS, CITY, STATE, ZIP CODE  1433 Ringwood Ave Haskell, NJ 07420	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>34421</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to maintain a dignified living environment for 1 of 35 residents reviewed (Resident # 83).</p> <p>The deficient practice was evidenced by the following:</p> <p>On 1/21/25 at 12:55 PM, the surveyor observed Resident # 83 in bed which was in a low position, with a sheet covering the resident. There was a staff member in the room seated next to the resident and the staff member stated that he was an aide who provided one-to-one care for Resident # 83. There were no personal belongings in the resident's room, and the wall in the resident's room were bare and had nothing on them. There was brown colored cardboard and tape covering over the air conditioning unit in the resident's room. The floor tiles were discolored and mismatched and there was an approximately 8-inch hole in the wall.</p> <p>At 1:00 PM, the surveyor interviewed the aide, who could not explain what happened and why the hole was there. The aide stated that Resident # 83 gets one to one supervision, 24 hours a day because the resident has behaviors of aggression, pulling things off the wall and has a history of knocking furniture over. The aide stated that the resident is blind in both eyes and cannot have furniture or belongings in the room as Resident # 83 will feel around the room and knock them down.</p> <p>At 1:10 PM, the surveyor interviewed the Licensed Practical Nurse, Charge Nurse, (LPN,CN) who stated that Resident # 83 is blind and has aggressive behaviors. She stated that the resident disrobed often and often became destructive of property as well. The LPN, CN stated that the resident cannot have personal belongings in their room. The LPN, CN stated that the air conditioning unit was covered and taped as Resident # 83 often tried to pull parts of the unit apart. The LPN, CN also stated that she did not know why there was a hole in the wall or why the floors looked like they did.</p> <p>A review of the resident's Admission Record revealed diagnoses which included, but were not limited to; behavioral and emotional disorders, autistic disorder, blindness to right and left eye, schizophrenia, anxiety, and intellectual disabilities.</p> <p>The resident has care plans in place for impaired visual function and disruptive and aggressive behaviors.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 11/1/24, revealed Resident # 83 had no Brief Interview for Mental Status, as the resident was assessed as rarely or never understood.</p> <p>On 1/22/25 at 12:27 PM, the surveyor discussed the above concerns with the Director of Nursing (DON) and the Administrator. The DON who stated that the resident is uncontrollable when they are angry, and the resident cannot have belongings in the room because they get ripped down and destroyed. The DON and Administrator stated that they could have done other things to make the room more homelike but had the resident's safety in mind. The DON and Administrator stated that they would look into why there was a hole in the room and will observe the floors too.</p> <p>On 1/22/25 at 1:14 PM, the surveyor interviewed the Maintenance Director (MD), who stated that he was aware of the hole in the resident's wall and the mismatched tiles. The MD did not know how long the hole was in the resident's wall and stated it should have been fixed. The MD stated that the facility does need to replace the flooring. The MD also stated that the facility put the cardboard and tape onto the air conditioning unit and there might be a way to make it look more homelike.</p> <p>A review of the facility's policy titled, Safe and Homelike Environment, dated 10/25/24 revealed that a homelike environment is one that de-emphasizes the institutional character of the setting.</p> <p>NJAC 8:39-4.1(a)12</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>36419</p> <p>Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain the call bell within reach of residents. This deficient practice was identified for 1 of 35 residents reviewed for the accommodation of needs (Resident # 39), and was evidenced by the following:</p> <p>On 1/21/25 at 11:38 AM, the surveyor observed Resident #39 in bed on a specialty mattress. The resident responded to the surveyor's greeting with a thumbs up and a smile. Resident #39 did not respond verbally. The surveyor observed Resident #39 had a tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe to help air and oxygen reach the lungs), with an oxygen concentrator in place infusing at 1.5 Liters per minute (lpm) via trach collar tubing. The surveyor observed that the resident's call bell (used to summon staff for assistance) was affixed to the left siderail, not within his/her reach.</p> <p>The surveyor reviewed the medical record for Resident #39.</p> <p>A review of Resident #39's Admission Record reflected that the Resident was admitted to the facility with diagnoses that included but were not limited to; tracheostomy, gastrostomy (tube surgically inserted into the stomach to deliver nutrition), aphasia (language disorder that affects a person's ability to communicate) respiratory failure, paraplegia (a condition that causes paralysis in the lower half of the body) urinary tract infection, and hemiplegia (a condition that causes weakness or paralysis on one side of the body) affecting their right dominant side.</p> <p>A review of Resident #39's quarterly Minimum Data Set (MDS), an assessment tool dated 12/18/24, revealed Resident #39 had severely impaired cognition. The MDS further assessed that the resident was dependent on staff for Activities of Daily Living (ADL) care.</p> <p>A review of Resident 39's Individualized Care Plan (CP) included a focus that indicated the resident was unable to verbalize his/her preferences with a goal that he/she would be asked questions that would allow him/her to utilize a thumbs-up/down for communication and facial expression. The CP did not include an intervention that addressed keeping their call bell within reach on their left side (diagnoses of right-sided hemiplegia).</p> <p>On 1/21/25 at 11:40 AM, the surveyor asked the Charge Nurse (CN) to accompany her to Resident #39's room. The surveyor and CN entered the Resident's room and observed the resident in bed and the call bell affixed to the left side rail, not within the resident's reach. The CN confirmed that the resident's call bell should have been placed within the resident's reach.</p> <p>On 1/21/25 at 11:45 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) assigned to Resident # 39's care (7 am-3:00 pm shift), who confirmed that the resident was able to use their call bell and that he should have placed it within the resident's reach.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/21/25 at 11:50 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to Resident #39's care (7 am-3:00 pm shift). The LPN acknowledged that the call bell should have been placed within Resident #39's reach. The LPN confirmed that Resident #39 was nonverbal and needed their call bell in order to summon staff assistance.</p> <p>A review of the facility's Call Bell Response policy and procedure revised 10/2024 indicated .the CNA will place the call bell within easy access for the resident .</p> <p>On 1/27/25 at 1:45 PM, the surveyor discussed the above observations and concerns with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The LNHA confirmed that the call bells should be placed within the residents' reach.</p> <p>NJAC 8:39- 31.8 (c)(9)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>34421</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to accurately develop and implement a person-centered comprehensive care plan for care and service needs. This deficient practice was observed for 1 of 35 residents reviewed, Resident # 28, as evidenced by the following:</p> <p>1. On 1/21/25 at 1:16 PM, the surveyor observed Resident # 28, in the dayroom and the resident was unable to answer the surveyor's questions.</p> <p>The surveyor reviewed Resident #28's Electronic Medical Records. Resident #28's face sheet revealed that the resident was admitted to the facility with diagnoses which included but were not limited to; pulmonary embolism.</p> <p>The Quarterly Minimum Data Set (MDS) an assessment tool dated 10/11/24, which revealed that there was no Brief Interview for Mental Status, as the resident was assessed as rarely or never understood.</p> <p>A review of the Physician's Order Sheet (POS) revealed the resident had a physician's order for Apixaban 5 mg 1 tablet by mouth twice daily. The surveyor reviewed the resident's current care plans. There was no comprehensive care plan developed regarding the resident's order for the anticoagulant medication.</p> <p>On 91/27/25 at 1:45 PM, the surveyor interviewed the Director of Nursing (DON), who stated that a care plan for the anticoagulant medication which was prescribed to Resident # 28 should have been created. The DON was unable to locate the care plan for the anticoagulant medication.</p> <p>The surveyor with the policy titled Care Plan, dated 12/2024, which revealed that the comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment.</p> <p>NJAC 8:39- 11.2 (e)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>36419</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to maintain professional standards of nursing practice by not following a physician's order for 2 of 35 of the residents (Resident #39 and #50) reviewed.</p> <p>The deficient practice was evidenced by the following:</p> <p>Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist.</p> <p>Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.</p> <p>1. On 1/21/25 at 11:38 AM, the surveyor observed Resident #39 in bed on a specialty mattress. The resident responded to the surveyor's greeting with a thumbs up and a smile. Resident #39 did not respond verbally. The surveyor observed Resident #39 had a tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe to help air and oxygen reach the lungs), with an oxygen concentrator in place with humidifier infusing at 1.5 Liters per minute (lpm) via trach collar tubing.</p> <p>The surveyor reviewed the medical record for Resident #39.</p> <p>A review of Resident #39's Admission Record reflected that the Resident was admitted to the facility with diagnoses that included but were not limited to; tracheostomy, gastrostomy (tube surgically inserted into the stomach to deliver nutrition), aphasia (language disorder that affects a person's ability to communicate) respiratory failure, paraplegia (a condition that causes paralysis in the lower half of the body) urinary tract infection, and hemiplegia (a condition that causes weakness or paralysis on one side of the body) affecting their right dominant side.</p> <p>A review of Resident #39's Order Summary Report (OSR) reflected Resident #39 had an active Physician's order (PO) Oxygen 28% FIO2 (fraction of inspired oxygen), the percentage of oxygen that a person inhales) to infuse at 3 Liters per minute (lpm) via a trach collar every shift with a start date of 11/11/24.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #39's quarterly Minimum Data Set (MDS), an assessment tool dated 12/18/24, revealed Resident #39 had severely impaired cognition. The MDS assessed that the resident was dependent on staff for Activities of Daily Living (ADL) care. The MDS further assessed that the Resident received Respiratory Care, which included Tracheostomy care and Oxygen Therapy.</p> <p>A review of Resident 39's Individualized Care Plan (CP) included a focus that indicated the resident had a Tracheostomy r/t respiratory failure with interventions, which included giving humidified oxygen as prescribed with an initiated date of 3/22/23.</p> <p>On 1/21/25 at 11:50 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to Resident #39's care (7 am-3:00 pm shift). The LPN confirmed that the Oxygen gauge was set at 1.5 lpm. The surveyor asked the LPN if that was what the physician ordered. The LPN replied that she would check the doctor's order. The LPN and surveyor reviewed the PO which indicated that the Oxygen was ordered to be delivered at 3 lpm. The LPN confirmed that she had not checked the oxygen settings that morning to ensure the resident had received the proper lpm.</p> <p>A review of the facility's Oxygen Therapy policy and procedure revised 10/2024 indicated .Adjust the rate of flow according to the doctor's orders.</p> <p>A review of the facility's Physician Order policy and procedure revised 10/7/24 indicated .Admission orders are verified with the physician .</p> <p>Any order that is in question must be repeated to the physician .Notify the nursing administration and medical director whenever an order that is questioned cannot be verified .</p> <p>On 1/27/25 at 1:45 PM, the surveyor discussed the above observations and concerns with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The DON stated that the respiratory therapists sometimes change the Oxygen settings but confirmed that the LPN should have been knowledgeable regarding the Oxygen order and administration.</p> <p>On 1/28/25 at 10:16 AM, the survey team met with the LNHA, DON, and Director of Respiratory Therapy (DOR). The DOR stated that the resident had received the appropriate FiO2 at 28% and that the respiratory therapists changed the gauges on the concentrators to ensure the resident received the proper concentration. The DOR further stated that the doctor should not write the order to include the lpm, that the orders come from the hospital, and that was why they were written that way. The DOR confirmed that the order should have been clarified with the physician and followed accordingly. The LNHA confirmed that the LPN should have clarified and followed the PO.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>45449</p> <p>NJ 175442</p> <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to maintain timely assistance with breakfast, and morning care (assistance with, but not limited to feeding, continence care, dressing, and grooming) for a resident who was totally dependent on staff for activities of daily living (ADL). This deficient practice was identified in 1 of 2 residents (Resident #169) reviewed for ADL and was evidenced by the following:</p> <p>On 1/21/25 at 11:07 AM, during the initial tour, the surveyor, from the hallway, observed Resident #169 in their room, seated in a wheelchair, well dressed, and was in the middle of a video conference call. The video conference device utilized by Resident #169 appeared mounted on a stand.</p> <p>The surveyor reviewed the medical record for Resident #169.</p> <p>According to the Admission Record, (an admission summary), reflected that Resident #169 was admitted to the facility with diagnoses that included the following: unspecified injury of the cervical spinal cord (damage to spinal cord), and neuromuscular dysfunction of the bladder (urinary incontinence).</p> <p>A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 11/7/24 reflected the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. In addition, the MDS further revealed there were no behaviors related to rejection of care, had the ability to understand staff, and the ability to be understood by staff. Resident #169 was totally dependent on staff for all activities of daily living (ADL; include eating, bathing, dressing, mobility and continence care).</p> <p>A review of the resident's individual comprehensive care plan (CP) included a focus area, that Resident #169 had difficulty with self-feeding related to paraplegia, initiated on 8/26/24. The associated intervention included a one-to-one feeding assistance by staff, initiated on 8/26/24. Further review of the CP reflected a focus on the resident's bowel and bladder incontinence, initiated on 2/2/24. The associated intervention included frequent and as required checks, cleansing, rinsing, drying of personal areas, change of clothing after incontinence episodes.</p> <p>A review of Resident #169's grievance form, dated 7/7/24 at 11:41 AM, revealed that the Social Worker (SW) was notified by the resident that they had not received any care, breakfast was not offered, and had not been fed.</p> <p>A review of the Certified Nursing Assistant (CNA #1's ) signed statement revealed that Resident #169 was originally assigned to a different CNA (CNA #2) who at that time was not in the building. CNA #1 was not informed that Resident #169 was added to her assignment of 19 residents in total. Resident #169 was not fed and not cleaned by 11:00 AM. The SW went to the facility to ensure care was rendered and the resident ate lunch.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/23/25 at 10:25 AM, during an interview with the surveyor, the SW stated that she had initially taken the complaint and notified the Assistant Director of Nursing (ADON) of the grievance.</p> <p>On 1/23/25 at 11:28 AM, during an interview with the surveyor, the ADON stated that she was informed by the SW and the incident had occurred on a Sunday. The ADON also stated that there was miscommunication, wherein the nurse on duty did not inform CNA #1 of the additional assigned residents that included Resident #169. The ADON stated that the breakfast was offered to the resident, but the resident refused since it was almost lunch time. The ADON confirmed that the resident had to be fed and was totally dependent for ADLs.</p> <p>At that time, the surveyor and the ADON reviewed the provided assignment sheet for 7/7/24. The ADON confirmed CNA #1 had 19 assigned residents and acknowledged that they were short staffed on that day.</p> <p>On 1/23/25 at 1:34 PM, in the presence of the survey team, and the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) stated that every resident needed to received care and staffing was a challenge, but they worked hard to meet the staffing needs. The DON acknowledged awareness of the staffing shortage for that day. The DON also stated that the staff was overwhelmed that day, and that the CNA did not know that the resident was re-assigned to her, all of which were summarily contributors to the delayed morning care and feeding of Resident #169, who was totalhly dependent on staff.</p> <p>A review of the provided facility policy, Activities of Daily Living dated/ revised 6/1/23, revealed that resident will gain/ or maintain as much independence as possible in ADLs which are essential to the individual's lifestyle.</p> <p>NJAC 8:39-4.1(a)22, 17.2(f)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36419</p> <p>Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that urinary drainage bags were stored and secured in a manner to prevent contamination and infection control. This deficient practice was identified for 2 of 3 residents reviewed (Resident # 39 and #70), and was evidenced by the following:</p> <p>1. On 1/21/25 at 11:10 AM, the surveyor observed Resident #70 in bed. The surveyor observed the resident had a tracheostomy with a large portable oxygen tank infusing at 6 Liters per minute (lpm) via trach collar tubing and two urinary drainage bags lying on top of the resident ' s bed, one on each side of the resident. The surveyor observed there were two privacy bags affixed to the lower aspect of the upper left and right-side rails.</p> <p>The surveyor reviewed the medical record for Resident #70.</p> <p>A review of Resident # 70 ' s Admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; acute kidney failure, nephrostomy catheter (a small flexible tube that drains urine from the kidney into a bag outside the body), a suprapubic catheter (a small flexible tube that drains urine from the bladder through a small incision in the lower abdomen and connected to a drainage bag outside the body), tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe to help air and oxygen reach the lungs), gastrostomy (tube surgically inserted into the stomach to deliver nutrition), aphasia (language disorder that affects a person ' s ability to communicate) and respiratory failure.</p> <p>A review of Resident #70 ' s quarterly Minimum Data Set (MDS), an assessment tool dated 12/27/24, revealed Resident #70 had severely impaired cognition. The MDS further assessed that the resident was dependent on staff for Activities of Daily Living (ADL) care and had an indwelling nephrostomy tube and suprapubic catheter.</p> <p>A review of Resident #70's Individualized Care Plan (CP) included a focus that indicated the resident had a right nephrostomy tube and a suprapubic catheter due to obstructive uropathy from kidney stones initiated on 2/28/20 with interventions that included keeping the drainage bag below bladder level.</p> <p>On 1/21/25 at 11:20 AM, the surveyor asked the Licensed Practical Nurse (LPN) assigned to Resident #70 ' s care (7 AM-3:00 PM shift) to accompany her to Resident #70 ' s room. The surveyor and LPN entered the resident ' s room and observed the two urinary drainage bags on the bed. The surveyor asked the LPN if the drainage bags should be stored in the privacy bags located on the lower aspect of the right and left upper side rails located below the bladder for privacy and proper drainage. The LPN again stated that the resident ' s mother wanted the bags in the bed.</p> <p>(continued on next page)</p>		

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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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/21/25 at 11:25 AM, the surveyor interviewed Resident #70 ' s Certified Nursing Assistant (CNA #1), who stated that the urinary drainage bags should be contained in the privacy bags that were affixed to the lower part of the side rails to ensure privacy and proper drainage. CNA#1 further stated that she had not provided care to the resident that morning and had not observed the urinary drainage bags in the bed.</p> <p>On 1/21/25 at 11:32 AM, the surveyor interviewed the Charge Nurse (CN), who confirmed that the urinary drainage bags should always be stored in privacy bags for privacy and below the bladder level for gravity and to prevent urinary tract infections.</p> <p>2. On 1/21/25 at 11:38 AM, the surveyor observed Resident #39 in bed on a specialty mattress. The resident responded to the surveyor ' s greeting with a thumbs up and a smile. Resident #39 did not respond verbally. The surveyor observed that Resident #39 had a tracheostomy, with an oxygen concentrator in place, infusing 1.5 Liters per minute (lpm) via trach collar tubing. The surveyor observed the urinary drainage bag was affixed to the lower aspect of the bedframe, not contained within the privacy bag that was hanging on the bedframe next to the drainage bag.</p> <p>The surveyor reviewed the medical record for Resident #39.</p> <p>A review of Resident #39's Admission Record reflected that the Resident was admitted to the facility with diagnoses that included but were not limited to; tracheostomy, gastrostomy, aphasia, respiratory failure, paraplegia (a condition that causes paralysis in the lower half of the body) urinary tract infection, and hemiplegia (a condition that causes weakness or paralysis on one side of the body) affecting their right dominant side.</p> <p>A review of Resident #39's quarterly MDS dated [DATE], revealed Resident #39 had severely impaired cognition. The MDS further assessed that the resident was dependent on staff for Activities of Daily Living (ADL) care and had an indwelling urinary catheter.</p> <p>A review of Resident #39's CP included a focus that indicated the resident had an Indwelling catheter; initiated on 1/18/22 with interventions that included positioning the catheter bag and tubing below the level of the bladder and away from the entrance room door initiated.</p> <p>On 1/21/25 at 11:45 AM, the surveyor and CN entered the Resident ' s room and observed the urinary drainage bag affixed to the left lower aspect of the bed frame with the privacy bag hanging next to the urinary drainage bag. The CN confirmed that the urinary drainage bag should have been stored properly within the privacy bag, not next to it.</p> <p>On 1/21/25 at 11:45 AM, the surveyor interviewed the CNA ( CNA #2) assigned to Resident #39 ' s care (7 am-3:00 pm shift), who confirmed that the resident ' s urinary drainage bag should have been stored in the privacy bag that was affixed to the lower left side of the bed for privacy and infection control.</p> <p>On 1/21/25 at 11:50 AM, the surveyor interviewed the LPN assigned to Resident #39 ' s care (7 am-3:00 pm shift). The LPN acknowledged that she should have placed the urinary drainage bag inside the privacy bag for dignity and infection control.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Phoenix Center for Rehabilitation and Pediatrics		STREET ADDRESS, CITY, STATE, ZIP CODE  1433 Ringwood Ave Haskell, NJ 07420	
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility ' s Catheterization (Foley) policy and procedure revised 10/2024 indicated .Position tubing and hang the drainage bag on the bed frame to provide optimal gravity drainage .always keep the catheter bag below the level of the bladder .</p> <p>On 1/27/25 at 1:45 PM, the surveyor discussed the above observations and concerns with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The DON confirmed that all urinary drainage bags should be kept below the level of the bladder and stored in privacy bags.</p> <p>NJAC 8:39- 31.8 (c)(9)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>36419</p> <p>Based on observation, interview, review of medical records, and other facility documentation, it was determined that the facility failed to complete post-dialysis assessments for residents on dialysis (a treatment that replicates the kidney's function and cleans the waste from blood for individuals with kidney disease or kidney failure).</p> <p>This deficient practice was identified for 2 of 2 residents (Resident # 127 and #179) reviewed for dialysis and was evidenced by the following:</p> <p>1. On 1/21/25 at 11:00 AM, during the initial tour of the 4th floor unit, the surveyor observed that Resident #127 was not in his/her room. The Charge Nurse (CN) stated that the resident was at dialysis. The CN stated that the resident received renal dialysis three times a week.</p> <p>On 1/27/25 at 8:00 AM, the surveyor observed Resident #127 in bed on a specialty mattress. The resident did not respond to the surveyor's greeting.</p> <p>The surveyor reviewed the medical record for Resident #127.</p> <p>A review of the Admission Record reflected Resident #127 was admitted to the facility with diagnoses that included but were not limited to; dependence on renal dialysis.</p> <p>A review of the most recent Minimum Data Set (MDS), an assessment tool dated 12/27/24, revealed Resident #127 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated that the resident's cognition was severely impaired.</p> <p>A review of Resident #127's medical record revealed that the resident was scheduled for hemodialysis (HD) on Tuesday, Thursday, and Saturday at 10:00 AM.</p> <p>An active Physician's Order, dated 11/24/23, indicated Blood Pressure monitoring pre and post-HD every Tuesday, Thursday, and Saturday; check BP prior to leaving for Dialysis and upon returning from Dialysis.</p> <p>A review of the HD communication log revealed that the facility completed the pre-dialysis assessments and the HD center completed the assessment while the resident was at the HD center. There was no portion on the communication log which reflected if the facility completed a post-HD assessment.</p> <p>On 1/27/25 at 8:10 AM, the surveyor interviewed the Registered Nurse (RN) on the 4th-floor unit, who stated that the dialysis communication binder would be sent with the resident on dialysis days. The nurse would complete the top section of the form, and the dialysis center would complete the bottom section. When the resident returned from dialysis the facility nurse would sign the bottom of the form and document the time the resident returned to the facility. The receiving nurse would then document the vital signs and post HD assessment in the Progress Notes.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The surveyor reviewed Resident #127's Progress Notes, which revealed that the facility nurses documented a post-HD assessment for some of the dates when the resident returned from the HD center, but the documentation was not consistent. There were no post-HD assessments, which included vital signs for the dates of 1/4/25, 1/7/25, 1/11/25, 1/16/25, 1/18/25, 1/21/25, 1/23/25, and 1/25/25.</p> <p>34421</p> <p>2. On 1/22/25 at 10:30 AM, the surveyor observed Resident #179 in their room and upon interview, the resident stated that they received renal dialysis three times a week. The resident stated that they could not recall if the resident was assessed when they returned to the facility from the dialysis center.</p> <p>The surveyor reviewed the medical record for Resident #179.</p> <p>According to the Admission Record, Resident #179 was admitted with diagnoses that included but were not limited to; end stage renal disease and dependence on renal dialysis.</p> <p>A review of the Admission Minimum Data Set (MDS), an assessment tool used to manage care, dated 11/5/24, revealed Resident #179 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated that the resident was moderately impaired for cognition.</p> <p>A review of Resident #179's medical record revealed that the resident was scheduled for hemodialysis (HD) on Tuesday, Thursday and Saturday at 10:15 AM.</p> <p>A review of the HD communication log revealed that the facility completed the pre-dialysis assessments and the HD center completed the assessment while the resident was at the HD center. There was no portion on the communication log which reflected if the facility completed a post-HD assessment.</p> <p>The surveyor reviewed Resident # 179's Progress Notes (PN), which revealed that the facility nurses documented a post-HD assessment for some of the dates when the resident returned from the HD center, but it was not consistent. There were no post-HD assessments for the dates of 2/19/24, 12/26/24, 12/28/24, and 1/9/25 in the PN's.</p> <p>On 1/27/25 at 1:45 PM, the surveyor discussed the above concerns with the Director of Nursing (DON) and the Administrator.</p> <p>On 1/28/25 at 10:16 AM, the Administrator stated that the facility is aware that the residents should have post-HD assessments done by the nursing staff and they will address this concern.</p> <p>A review of the facility provided policy End-Stage Renal Disease, Care of a Resident dated/revised 1/28/24 reflected that Agreements between this facility and the contracted ESRD facility included all aspects of how the resident's care will be managed, including how information will be exchanged between the facilities. The general medical nurse should document in the resident's medical record every shift as follows: location of catheter, condition of dressing (interventions if needed), if dialysis was done during shift, any part of report from dialysis nurse post-dialysis being given and observation post dialysis.</p> <p>NJAC 8:39 - 27.1 (a)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>34421</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to store 1 of 35 residents (Resident # 83) personal clothing in a sanitary manner. This deficient practice was as evidenced by the following:</p> <p>On 1/21/25 at 12:55 PM, the surveyor observed Resident # 83 in bed which was in a low position, with a sheet covering the resident. There was a staff member in the room seated next to the resident and the staff member stated that he was an aide who provided one-to-one care for Resident # 83. The surveyor observed that inside the resident's bathroom, the resident's clothing was on hangers and located hanging on the shower curtain rod, which was approximately 5 feet from the resident's toilet.</p> <p>At 1:00 PM, the aide stated that Resident # 83 gets one to one supervision, 24 hours a day because the resident has behaviors of aggression, pulling things off the wall and has a history of knocking furniture over. The aide stated that the resident is blind in both eyes and cannot have furniture or belongings in the room as Resident # 83 will feel around the room and knock them down. The aide stated that Resident # 83 uses the toilet in the bathroom on occasion and is incontinent at times too but gets showers in the communal shower room.</p> <p>At 1:10 PM, the Licensed Practical Nurse, Charge Nurse, stated that the resident's clothing was stored in their bathroom, on the shower rod because the resident could not have a dresser or closet in their room, but stated that there could be a better way to store it more hygienically, like in a container.</p> <p>On 1/22/25 at 12:27 PM, the surveyor discussed the above concerns with the Director of Nursing (DON) and the Administrator. The DON stated that the clothing was stored in the resident's bathroom because the resident knocks over furniture in their room and they will look into storing the clothing in a different way to prevent concerns with infection control.</p> <p>N.J.A.C. 8:39-19.4(a)</p>