| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315199 | A. Building<br>B. Wing | 08/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Imperial Care Center | 919 Green Grove Road<br>Neptune, NJ 07753 |

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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>38680<br><br>Based on observation, interview, and review of medical records and other facility documentation, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS) for 1 of 20 residents reviewed (Residents #12). This deficient practice was evidenced by the following:<br><br>On 08/21/2024 at 9:44 AM, the surveyor observed Resident #12 in the bed.<br><br>The surveyor reviewed the Admission Record for Resident #12 which reflected that the resident was admitted with diagnoses that included Chronic Obstructive Pulmonary Disease (disease of the lung).<br><br>The surveyor reviewed the Physician's orders for Resident # 12. There was an order dated 07/24/2023 for Oxygen at 2 liters per minute via nasal cannula continuous every shift. The July 2024 Medication Administration Record had documentation that the Oxygen was in use.<br><br>The surveyor reviewed Resident #12's Quarterly MDS, an assessment tool utilized to facilitate the management of care, dated 07/19/2024. The MDS indicated no for Oxygen use for Resident #12.<br><br>When interviewed on 08/26/24 at 11:36 AM, the MDS Coordinator stated that Resident #12 utilized Oxygen. He stated that the July 2024 MDS was coded incorrectly.<br><br>NJAC 8:39-11.2 |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 315199 | A. Building<br>B. Wing | 08/27/2024 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38680<br><br>Based on observation, interview, and record review it was determined the facility failed to conduct a new Preadmission Screening and Resident Review (PASRR) assessment after a resident was newly diagnosed with a mental illness. This deficient practice was identified in 1 of 1 resident reviewed for Preadmission Screening and Resident Review PASRR (Resident #55) and was evidenced by the following:<br><br>Resident #55 was a resident of the facility. The surveyor reviewed the Level I PASRR (a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) for Resident #55 dated 07/04/2020 which was negative, meaning the resident did not have any mental illness diagnoses that could lead to a chronic disability.<br><br>The surveyor reviewed the quarterly Minimum Data Set (MDS), an assessment tool dated 12/22/2021. The MDS reflected that Resident #55 had long and short-term memory deficits and did not have diagnosis of schizophrenia (a serious mental illness). The surveyor reviewed the quarterly MDS dated [DATE]. The MDS reflected Resident #55 had long and short-term memory deficits and had diagnosis which included schizophrenia.<br><br>The surveyor reviewed the psychiatry consult for Resident #55 dated 02/01/2022. The consult included diagnoses of dementia and major depression with psychotic features. The surveyor reviewed the psychiatry consult for Resident #55 dated 03/01/2022. The consult included a new diagnosis of schizophrenia.<br><br>During an interview with the surveyor on 08/22/2024 at 11:12 AM, the Clinical Social Worker stated that when a resident was diagnosed with a new psychiatric disorder, a new PASRR should be completed. She stated that when Resident #55 was newly diagnosed with schizophrenia a new level I PASRR should have been completed but was not.<br><br>The surveyor reviewed the facility policy titled, PASRR Completion, with an issue date of 10/10. The policy reflected that PASRR screening will be completed in compliance with state and federal regulations.<br><br>NJAC 8:39-27.1 (a) |