STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315381	A. BUILDING _____ B. WING _____	04/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMER HILL NURSING HOME	111 ROUTE 516 OLD BRIDGE, NJ 08857

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS CENSUS: 67 SAMPLE SIZE: 21 + 6 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the	F 582		4/30/21

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

Electronically Signed | 04/29/2021

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F 582	Continued From page 1 Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to provide written notification to the beneficiary of the potential liability charges for services not covered, when the resident was discharged from Medicare Part A services with benefit days remaining. This deficient practice was identified for 2 of 3 residents reviewed for beneficiary notice reviews (Resident #14 and Resident #55), and was evidenced by the following: On 4/15/21 at 11:20 AM, the surveyor reviewed	F 582	Corrective Action; Resident # 14 and 55 medical records were reviewed for the deficient practice. The Advance Beneficiary Notice forms were reviewed with resident #14 and 55 and the forms were completely filled out. Resident #14 and 55 decline to continue with Physical Therapy services. Administrator in serviced the Admission Director on the facility policy and regulations and on how to properly complete the Advance Beneficiary (ABN) form	

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F 582	Continued From page 2 the facility provided Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) Forms for Resident #14 and Resident #55 which revealed the following: Resident #14's SNFABN form, provided to the resident on [redacted], indicated that "Beginning on [redacted] you may have to pay out of pocket for this care if you do not have any other insurance that may cover these costs." Under the section for "Care" included that the resident may have to pay out of pocket for "physical [and] occupational therapy." Under the sections for "Reason Medicare May Not Pay" and "Estimated Cost" used to inform the resident of any liability costs not covered by insurance, the areas were left blank. Resident #55's SNFABN form, provided to the resident on [redacted], indicated that "Beginning on [redacted] you may have to pay out of pocket for this care if you do not have any other insurance that may cover these costs." Under the section for "Care" included that the resident may have to pay out of pocket for "physical therapy [and] occupational therapy." Under the sections for "Reason Medicare May Not Pay" and "Estimated Cost" used to inform the resident of any liability costs not covered by insurance, the areas were left blank. There was no documented evidence that the facility provided Resident #14 and Resident #55 the estimated cost of their liability not covered by insurance upon discharge from Medicare Part A services. On 4/15/21 at 11:29 AM, the surveyor interviewed the Admissions Director (AD) regarding the	F 582	Identification of at risk residents: All Long-Term residents receiving special skilled serviced are potentially at risk for the deficient practice. This can be identified by reviewing the medical records. Systemic Changes: An audit was done of all Long Term residents currently in the facility who received special skilled services in the last six months for completion of the Advance Beneficiary notice (ABN). All the residents had an ABN done. The residents that did not have a fully completed ABN were provided with the information and the forms were completely filled out. None of the residents wanted to continue with the special skilled Therapy services. The Administrator in serviced the Admission Director on the facility policy and regulations and on how to properly complete the Advance Beneficiary (ABN) form Quality Assurance: An audit of the completed ABN forms will be done by the Admission Director/ Designee weekly for 4 weeks and then monthly for six months. The Administrator /designee will do weekly random audit of five completed ABN forms for 4 weeks and monthly for six months. Any issues will be corrected immediately and reported to the Quality Assurance/QAPI Committee quarterly for six months or until compliance is met.	

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F 582	Continued From page 3	F 582		

blanks on the SNFABN forms for Resident #14 and #55. The AD stated that she did not place the cost on the SNFABN forms because she did not know what the price would be. She then stated that if the resident declined the service there would be no need to the provide the liability costs, but that if there was an interest [for the services] that she would follow up with the resident and get a price list from the therapy department or other department if needed. She further stated that she would not know what the potential services would be that were needed and could not give a "guesstimate."

On 4/19/21 at 9:10 AM, the Regional Nurse and the Licensed Nursing Home Administrator (LNHA) stated in the presence of the survey team, that there should not be any blanks on the SNFABN form and that going forward an estimated cost of liability would be included on the form, even if the resident agrees to be discharged from services. The LNHA acknowledged costs not covered by insurance should be provided to the resident even if the resident agreed to have services end. The Regional Nurse stated that the two residents were interviewed and there were was no subsequent negative outcomes.

The surveyor reviewed the facility provided policy titled, "Advance Beneficiary Notice of Noncoverage" with an updated date of October 2020, which included, "It is the policy of this facility to issue a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) if there is a reason to believe that Medicare Part A may not cover or continue to cover a resident's care or stay because it isn't reasonable or necessary or is considered Custodial Care." ...Under Policy

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F 582	Continued From page 4 Interpretation and Implementation: "The SNFABN will let a resident know that Medicare will likely no longer pay for their services. If a resident chooses to get the services that Medicare may not cover, the resident does not have to pay for these services until a claim is submitted and Medicare officially denies payment. However, while the claim is processed, the resident will have to continue paying costs that they normally have to pay like the daily coinsurance and costs for services and supplies Medicare generally doesn't cover." NJAC 8:39-5.4 (b)(c)	F 582		
F 885 SS=C	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a	F 885		4/20/21

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F 885	Continued From page 5 confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure resident representatives were informed of a newly confirmed COVID-19 diagnosis of a staff member in the facility by 5 PM the next calendar day. This deficient practice was identified for 1 of 1 staff who tested positive for COVID-19 (Licensed Practical Nurse). The evidence was as follows: On 4/12/21 at 10:09 AM, the surveyor conducted a survey entrance conference with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant Director of Nursing/Infection Preventionist (ADON/IP) and the Regional Nurse. The DON stated that the facility was not currently in a COVID-19 outbreak, but that they recently had a Licensed Practical Nurse (LPN) test positive for COVID-19 on 4/6/21. The DON stated that the LPN had a COVID-19 test on [redacted] using the Polymerase Chain Reaction (PCR) (a specific DNA sample method to determine presence of, in this case, COVID-19), and the positive COVID-19 results via PCR were reported to the facility on Friday [redacted] The DON stated that the LPN was asymptomatic (had no signs or symptoms). A review of the COVID-19 line list for staff revealed the same, that the LPN had tested positive for COVID-19 on [redacted].	F 885	Corrective Action The LNHA designated another 2 Employees to be able to send out the Covid notification calls in the Event that the LNHA is not available. These Staff members were in serviced regarding the regulation that the notification needs to be sent out by 5pm the day after the facility is notified of the covid positive case Identification of at risk residents All residents in the facility were potentially at risk for this deficient practice Systematic Changes The LNHA in-serviced the staff regarding the Regulation that the calls need to be sent out at 5pm the next day following identification of a Covid Positive case. The LNHA designated other staff members that can send out the Notification Quality Assurance The Lnha and Qapi team will review this on a monthly basis to ensure that the facility in is compliance with the regulation F885	

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F 885	Continued From page 6	F 885		

A review of the COVID-19 PCR laboratory result for the LPN reflected that the nasal swab sample was collected on [redacted] with an abnormal "Positive" result. The positive lab result indicated that the result was verified and reported to the facility on [redacted].

A review of the Confirmation "Robo call" notification receipt dated Monday [redacted] at 11:33 AM reflected that the family representatives of residents were notified via a Robo call.

On 4/14/21 at 1:12 PM, the surveyor interviewed the LNHA who stated that he was notified of the positive COVID-19 case for the LPN late [redacted] night [redacted]. He stated that he was usually responsible for notification of families via the Robo call system. He stated that he was not available over that weekend to send the notification out to to the families, but stated that the DON or the Corporate Central Office could also do it. The LNHA acknowledged that the "Robo call" receipt confirmation email was the Robo call sent out to notify families of the new COVID-19 case in the building. The LNHA acknowledged that the families should have been notified on [redacted] by 5 PM, and acknowledged that family notification on [redacted] was nearly two days later than required.

On 4/19/21 at 9:47 AM, the LNHA provided the surveyor a copy of the Notification of Confirmed COVID-19 (or COVID-19 Persons Under Investigation) Among Residents and Staff in Nursing Homes policy dated 4/27/2020 included that "At a minimum, this facility will inform residents and their representatives within 12-24 hour of the occurrence of a single confirmed infection of COVID-19, or three or more residents

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F 885	Continued From page 7 or staff with new onset of respiratory symptoms that occur within 24 hours. All POA [Power of Attorney] should be contacted by the facility phone call... In addition, the information contained above, will be readily available to the administrator and a designated person on a daily basis (in case that person is unavailable)..." The LNHA was unable to provide any additional documentation that families were notified by 4/10/21 at 5 PM when the new COVID-19 positive case was confirmed on 4/9/21. NJAC 8:39-5.1 (a)	F 885		