STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315068	A. BUILDING _____ B. WING _____	C 10/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DWELLSIDE CARE AND REHAB	**3025 CHAPEL AVENUE WEST CHERRY HILL, NJ 08002**

(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 Monitoring Visit Census: 99 Sample Size: 5 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence.	F 636		11/24/21

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

Electronically Signed | 11/17/2021

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.

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F 636	Continued From page 1 (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Monitoring Visit	F 636	1. The Annual MDS of Resident #1 was completed on October 27, 2021. The	

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DWELLSIDE CARE AND REHAB	**3025 CHAPEL AVENUE WEST CHERRY HILL, NJ 08002**

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F 636	Continued From page 2 Based on interview and record review, it was determined that the facility failed to complete the Annual Minimum Data Set (MDS), a periodic and federally mandated, standardized assessment tool, within the required time frame. This deficient practice was identified for 2 of 5 residents (Resident #1 and #2) reviewed for comprehensive assessments. This deficient practice was evidenced by the following: The Centers For Medicare and Medicaid (CMS.) Resident Assessment Instrument (RAI.) Version 3.0 Manual classified the Observation (Look Back) Period as the time period over which the resident's condition or status was to be captured by the MDS. The Assessment Reference Date (ARD) referred to the last day of the observation (or "look back") period that the assessment covered for the resident. At a minimum, facilities are required to complete a comprehensive assessment for each resident within 14 calendar days after admission to the facility, when there is a significant change in the resident's status and not less than once every 12 months while a resident, where 12 months refers to a period within 366 days. The Electronic Medical Records (EMR) reviewed on 10/26/2021 at 11:20 a.m., were as follows: 1. According to the "Admission Record (AR)," Resident #1 was admitted to the facility on [redacted], with diagnoses which included but were not limited to [redacted]	F 636	Annual MDS of Resident #2 was completed on October 26, 2021. 2. All residents have the potential to be affected by the deficient practice. 3. The Administrator provided re-education to the IDCP team on November 10, 2021. Education focused on: review of MDS assessment period timelines including Admission, Significant Change, Quarterly and Annual. The IDCP tam will review during clinical morning meeting the UDA scheduled assessment list for MDS's due within an assessment period and will complete their respective sections. The MDS Coordinator and or designee will perform weekly audits in Point Click Care (EMR System) on timely completion of scheduled MDS's x4 weeks, then 2x a month for 3 months. 4. The Director of Nursing or designee will report audit results during the monthly QAPI meeting x3 months. The QAPI is attended by the Administrator, Director of Nursing, Medical Director and Department Heads.	

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DWELLSIDE CARE AND REHAB	**3025 CHAPEL AVENUE WEST CHERRY HILL, NJ 08002**

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F 636	Continued From page 3 NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted]	F 636		

The EMR showed that an Annual Minimum Data Set (MDS), an assessment tool used for evaluating the status of a resident, had an assessment reference date (ARD) of 10/7/2021 for Resident #1. Further review of the EMR revealed that the Annual MDS had not been completed as of 10/26/21.

2. According to the AR, Resident #2 was admitted on [redacted] with diagnoses which included but were not limited to [redacted]

The EMR revealed that an Annual MDS had an ARD of 8/25/2021 for Resident #2. Further review of the EHR revealed that the Annual MDS had not been completed as of 10/26/2021.

During a phone interview on 10/26/2021 at 4:08 p.m., the Minimum Data Set Coordinator/Registered Nurse (MDSC/RN) stated, "the annual (MDS) would still be in progress if someone did not complete a section or missing information so it would not lock." She further stated the assessment tells you how to take care of a (patient) resident.

Review of an undated facility policy titled "Minimum Data Set (MDS 3.0) Policy/Procedure" revealed the following: Under "Policy" included: "It is the policy of this facility to have a comprehensive assessment conducted on all resident in accordance with regulatory

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F 636	Continued From page 4 requirements; utilizing the RAI (Resident Assessment Instrument) and MDS 3.0 pursuant to Federal guidelines and timeframes. A comprehensive MDS assessment is to be completed on each resident under the following conditions: a. Within 14 days of admission ...c. Annually (no longer than 366 days from previous annual/admission MDS)," Under "Procedure:... The MDS Coordinator will provide each department with a schedule of all other upcoming MDS dates for Annual/Quarterly/Significant Change at least one month in advance ...."	F 636		
F 638 SS=D	N.J.A.C.: 8:39-11.2 (a), (d) Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Monitoring Visit Based on observations, interviews, and review of other facility documents on 10/25/2021 and 10/26/2021, it was determined that the facility failed to complete the Quarterly Minimum Data Set, a periodic and federally mandated, standardized assessment tool, within the specified timeframe as required, and also failed to follow its policy titled "Minimum Data Set (MDS 3.0) Policy/Procedure." This deficient practice was identified for 1 of 5 residents (Residents #1)	F 638	1. The Quarterly MDS of Resident #1 was completed on October 27, 2021. 2. All residents have the potential to be affected by the deficient practice. 3. The Administrator provided re-education to the IDCP on November 10, 2021. Education focused on: review of MDS assessment period timelines including Admission, Significant Change, Quarterly and Annual. The IDCP team	11/24/21

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F 638	Continued From page 5 whose MDS assessments were reviewed and was evidenced by the following: The Centers for Medicare and Medicaid (CMS) Minimum Data Set Version 3.0 Manual classified the Observation (Look Back) Period as the time period over which the resident's condition or status was to be captured by the MDS. The Assessment Reference Date (ARD) referred to the last day of the observation (or "look back") period that the assessment covered for the resident. The Quarterly assessment was considered timely if 1). The Assessment Reference Date (ARD) of the Quarterly MDS was within 92 days after the ARD of the previous MDS and 2). the completion date was no later than 14 days after the ARD. The Electronic Medical Records (EMRs) reviewed 10/26/2021 at 11:20 a.m. were as follows: According to the "Admission Record (AR)," Resident #1 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted] The EMR revealed Resident #1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/9/2021 was still not completed as of 10/26/21. During a phone interview on 10/26/2021 at 4:08 p.m., the Minimum Data Set Coordinator/Registered Nurse (MDSC/RN) stated	F 638	will review during clinical morning meeting the UDA scheduled assessment list for MDS's due within an assessment period and complete their respective sections. The MS Coordinator and or designee will perform weekly audits in PCC on timely completion of scheduled MDS's x4 weeks, then 2x a month for 3 months. 4. The Director of Nursing and or designee will report audit results during the QAPI meeting x3 months. The QAPI is attended by the Administrator, Director of Nursing, Medical Director and Department Heads.	

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F 638	Continued From page 6 the quarterly assessments were completed every 92 days. The MDSC/ RN stated she works at the facility peridiem, so several of the MDS's were now late. A review of an undated facility policy titled "Minimum Data Set (MDS 3.0) Policy/Procedure" revealed the following: Under "Policy," included: d. Quarterly MDS assessment is done on all residents no longer than every 92 days	F 638		
F 812 SS=B	N.J.A.C.:8:39-11.2 (h); 23.2 (b) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		11/24/21

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F 812	Continued From page 7 by: Monitoring Visit Based on observations, interviews, and review of pertinent facility documentation on 10/25/2021 and 10/26/2021, it was determined it was determined that the facility failed to discard outdated foods in the unit refrigerator and the pantry. The facility also failed to follow its policy titled "Use of Leftovers." This deficient practice was evidenced by the following: On 10/25/2021, the surveyors toured the [redacted] unit's pantry on the [redacted] floor and the [redacted] unit pantry on the [redacted] floor and observed the following: At 10:17 a.m., on the [redacted] floor, there were twelve cups of applesauce in the refrigerator dated 10/20, two cups of applesauce undated, one cup of tapioca pudding undated, and one cup of pineapple undated. At 10:27 a.m., there were three applesauce containers in the [redacted]-floor refrigerator with a date of 10/21/2021. During an interview on 10/25/2021 at 10:27 a.m., The Food Service Director (FSD) stated, "the three applesauce containers are from the weekend." The FSD explained that 10/21/2021 was the use-by date, and there should be a used-by date and expiration date on the container. During a second interview at 12:38 p.m., the FSD indicated the foods were good for three days after it was opened.	F 812	1. No residents were identified. 2. All residents have the potential to be affected by the deficient practice. The following corrective actions were taken: the following identified food items on the [redacted] floor were immediately dispose of: twelve cups of applesauce dated 10/20, two cups of applesauce undated and one cup of tapioca pudding undated and once cup of pineapple undated. The following food items identified on the [redacted] floor were immediately disposed of: three apple sauces dated 10/21. 3. The Food Service Director provided re-education to the Food Service Staff beginning October 26, 2021. Education focused on: Review of the policy "Use of Leftovers" and procedure for labeling and dating all perishable food items. The Food Service Director implemented a Checklist for unit pantries, unit refrigerators and kitchen refrigerators/freezers for outdated and unlabeled food items. The Food Service Director, Dietician and or designee will utilize the new Checklist to conduct weekly department audits x4 weeks and then 2x a month for 3 months to ensure proper disposal of out dated items and proper labeling of items. 4. The Food Service Director or designee will audit the Checklist results and report findings during the QAPI meeting x3	

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F 812	Continued From page 8 Review of an undated facility policy titled "Use of Leftovers", revealed the following: Under "Policy" included: "Leftovers will be properly handed and used or discarded as appropriate. Excess leftovers should be avoided ..." Under "Procedure:" included " ...6. Leftover foods will be used within three (3) days after the preparation date and then discarded the next day ..." N.J.A.C.: 8:39-17.2(g);19.7(d)	F 812	months. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315068 Y1	A. Building B. Wing Y2	11/26/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DWELLSIDE CARE AND REHAB	3025 CHAPEL AVENUE WEST CHERRY HILL, NJ 08002

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0636	Correction	ID Prefix F0638	Correction	ID Prefix F0812	Correction
Reg. # 483.20(b)(1)(2)(i)(iii)	Completed	Reg. # 483.20(c)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	11/24/2021	LSC	11/24/2021	LSC	11/24/2021
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/26/2021	☐ YES ☐ NO