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 _____	04/20/2023

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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Survey Date: 04/20/23 Census: 128 Sample: 36 plus 2 closed records 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 567 SS=E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit	F 567		5/22/23

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

Electronically Signed | 05/10/2023

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.

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 _____	04/20/2023

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 567	Continued From page 1 any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of pertinent facility documentation it was determined the facility failed to follow resident rights for the distribution of funds from a resident's personal needs allowance (PNA). This deficient practice was identified for five (5) of five (5) residents (Resident #30, #47, #56, #72 and #87) who attended a Resident Council (RC) group meeting and was evidenced by the following: On 04/14/23 at 11:04 AM, the surveyor conducted RC with five (5) residents (Resident #30, #47, #56, #72 and #87), who were [redacted] and regularly attended the RC group meeting. During the RC meeting, five (5) out of five (5) residents had complaints regarding their PNA.	F 567	Protection Management of PNA F567 SS=E 1. How will those affected by the deficient practice be corrected? Residents #30, #47, #56, #72 and #87 were identified during Resident Council with concerns regarding distribution of funds from their personal needs allowance (PNA). Resident council was held on April 24th, 2023, where the Administrator reviewed the findings from the Annual State Survey to include notification that the facility is increasing the PNA amount available at the front desk.	

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 _____	04/20/2023

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 567	Continued From page 2 They stated that they should not be told several times during the day that there was not enough money for withdrawal. They all stated that the facility should make sure that there was an ample amount of funds at the facility. Resident #87 stated that they were limited to [redacted] a day. Resident #47 stated that the Licensed Nursing Home Administrator (LNHA) should have allowed more money to be kept at the facility. Resident #87 stated that there was an issue with the "execution of the accounting department" because every day we were told that the facility did not have any money in the PNA account. The surveyor reviewed the electronic medical record (EMR) for Resident #30. A review of the resident's Admission Record (AR) reflected that the resident was initially admitted to the facility [redacted] and readmitted [redacted] with diagnoses which included: [redacted]). A review of the most recent Annual Minimum Data Set (MDS-an assessment tool utilized to facilitate the management of care) dated [redacted], reflected a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated an [redacted]. The surveyor reviewed the EMR for Resident #47. A review of the resident's AR reflected that the resident was admitted to the facility [redacted], with diagnoses which included: [redacted]).	F 567	2. How will you identify all other residents having the potential to be affected? All residents have the potential to be affected by the deficient practice. 3. What systemic changes will you make to ensure deficient practice doesn't occur again. The Administrator provided education to the Receptionists beginning April 21, 2023. Education included: • review of the updated PNA policy increasing available funds to $1,000 • updated posting of banking hours displayed at reception desk of 7 days a week during suggested visiting hours of 8:00am to 8:00pm • implementation of the PNA audit tool The Lead Receptionist and or designee will utilize the new PNA audit tool to document per resident request for PNA funds. The receptionist will immediately report any concern with insufficient funds to the Administrator to obtain additional available funds the same day. The Administrator will conduct weekly audits for 3 months to ensure available funds per resident request. 4. How will these actions be measured? The Administrator or designee will audit the PNA audit tool results and report findings during the Quality Assurance Performance Improvement (QAPI) meeting scheduled for May 25th, 2023,	

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 _____	04/20/2023

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 567	Continued From page 3 A review of the most recent annual MDS dated [redacted], reflected a BIMS score of [redacted] which indicated an [redacted] The surveyor reviewed the EMR for Resident #56. A review of the resident's AR reflected that the resident was admitted to the facility [redacted], with diagnoses which included: [redacted] A review of the most recent annual MDS dated [redacted], reflected a BIMS score of [redacted] which indicated an [redacted]. The surveyor reviewed the EMR for Resident #72. A review of the resident's AR reflected that the resident was initially admitted to the facility [redacted] and readmitted [redacted] of [redacted] with diagnoses which included: [redacted] A review of the most recent admission MDS dated [redacted], reflected a BIMS score of [redacted] out of [redacted] which indicated an [redacted]. The surveyor reviewed the EMR for Resident #87. A review of the resident's AR reflected that the resident was initially admitted to the facility [redacted] and readmitted [redacted], with diagnoses which included: [redacted] A review of the most recent annual MDS dated	F 567	and then monthly x3 months. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads.	

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 _____	04/20/2023

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 567	Continued From page 4 [redacted], reflected a BIMS score of [redacted] which indicated an [redacted]. On 04/14/23 at 12:39 PM, the surveyor interviewed the facility's Receptionist who was responsible to the distribution of the PNA funds to the residents. The Receptionist stated that she received PNA money from the Corporate Office on a weekly basis on [redacted]. The Receptionist told the surveyor that she would frequently run out of money and not be able to supply the residents with funds if they requested them. The Receptionist told the surveyor that she received approximately [redacted] a week from the Corporate Office. The process included her e-mailing the Corporate Office and the facility's LNHA to request a check, the Corporate Office would then scan and e-mail a check back to the LNHA, the LNHA would cash the check and then supply the Receptionist with the resident's money from their PNA. The surveyor asked the Receptionist what she would do if a resident wanted more money, and the funds were not available? The Receptionist stated, "We only get so much." The surveyor asked, "How come?" The Receptionist replied that she wasn't quite sure. The Receptionist then explained that the facility had to put a limit on the amount of money because if a resident asked for [redacted] of their money, the facility wouldn't have the funds readily available and would have to reach out to the Corporate Office, put an additional request in, and the resident would have to wait. The Receptionist stated that the Corporate Office would address each resident individually if they made a request for more money. The Receptionist further stated that it was frustrating for her because sometimes she would have a resident that would request [redacted] but she only had	F 567		

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 _____	04/20/2023

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 567	Continued From page 5	F 567		

[redacted] to give them and she would have to "negotiate" with the resident, put in a check request, and the resident would not be able to receive their money all at once. The Receptionist told the surveyor that it would take a day or two for the facility to receive the resident's money from their PNA that was controlled by the Corporate Office. The surveyor asked the Receptionist if the facility not having PNA funds available for the resident's was a problem. The Receptionist stated, "To be honest it is a problem for the residents, and I do my best to help them. Hopefully they will change the process."

On 04/18/23 at 11:35 AM, the survey team interviewed the LNHA who stated that that the residents had access to their PNA funds seven (7) days a week during business hours of 8:00 AM to 8:00 PM. She stated that the person that had access to the safe was the receptionist who hours were 8:00 AM to 8:00 PM. The LNHA stated that the receptionist would complete a check request which were sent to the corporate office. She further stated that the corporate office then sent her an electronic check which typically took one (1) day, and then she would have to go the bank to cash the check. The LNHA stated that the funds were replenished weekly which was typically around [redacted]. The survey team inquired about the $[redacted] limit per day and the LNHA stated that they did not set a limit on how much a resident could take out. The survey team continued to interview the LNHA regarding if the facility did not have any funds in the PNA. The LNHA explained that if they did not have enough money than they would submit a check request. She further explained if the resident wanted more money then the facility had available, the receptionist would complete a check request for

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 _____	04/20/2023

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 567	Continued From page 6	F 567		

that specific resident. She further stated that if they did not have the funds available then the receptionist would put in a check request and the residents would have to wait at least another day for the resident to withdrawal money. The LNHA then stated that sometimes she had to "front the money" from her own personal funds to the residents and then take the money out of the PNA funds to replace the amount that she provided to the resident.

On 04/18/23 at 12:25 PM, the survey team interviewed the Corporate Office Manager (COM) for the facility who stated that the process for PNA funds was the residents received their checks at the beginning of the month. She further stated that the resident received [redacted] per month and the balance was sent to the facility. The COM stated that the facility was allocated a certain amount of petty cash which was around [redacted] She stated that the allocated amount was determined by the request from the facility. The COM emphasized if the facility needed additional funds they could request for an increase in petty cash. She further stated that the facility's funds would be replenished based on their request that was sent to the corporate office. The COM stated if the facility required additional funds for the residents the facility would let the corporate office know and the corporate office would send the funds to the LNHA for it to be dispersed to the residents. The survey team ask how long it took for the facility to receive the funds requested? The COM stated, "right away." When asked for clarification on "right away. The COM stated if the Director of Nursing (DON) requested funds today then the corporate business office would send the check right away, so the resident could get their money. The survey team then asked according to

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 _____	04/20/2023

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 567	Continued From page 7	F 567		

the federal regulations how long should the residents have to wait to get their money? The COM could not speak to that and stated, "They get their money right away because the DON has petty cash". The statement contradicted the previous interviews with the Receptionist and LNHA.

A review of the Bank Hours for PNA withdrawals reflected the following: Monday to Friday 8:30 AM to 4:30 PM; Saturday and Sunday 8:30 AM to 2:00 PM only. It further reflected, please note anything over [redacted] will need a check request.

A review of the PNA cash report from 04/11/23 to 04/17/23, revealed that $[redacted] was the max amount of cash given and totaled less than $[redacted]

A review of the Funds Balance as of 04/17/23, reflected there was more than [redacted] in the resident's facility managed account.

On 04/19/23 at 02:02 PM, the LNHA in the presence of the DON and the survey team stated that she needed to update the signage at the receptionist desk because the receptionist thought the residents were limited to $[redacted] a day. She further stated that the residents should be able to receive at least [redacted] a day from the PNA funds.

A review of the facility's Admission Agreement under Resident's Finances included, "The Resident may deposit funds into a Facility managed account called a PNA Account. The Facility will make arrangements to hold such funds in accordance with all legal requirements and will make periodic disbursements to the Resident and provide the Resident with all

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 _____	04/20/2023

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 567	Continued From page 8 necessary documentation and information, consistent with the Facility's policies and procedures." A Review of the facility's undated Patient Needs Allowance (PNA) Policy included, "2. Petty cash in the amount of [redacted] is to be kept for small requests and should be replenished on a weekly basis. 3. Requests for $[redacted] or more need to be made in writing and will be sent for processing." NJAC 8:39-4.1(a)7-9	F 567		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documentation it was determined the facility failed to: a.) ensure staff consistently document the [redacted] from the [redacted] bag for, (Resident #41), b.) ensure staff consistently follow a Physician Order (PO) to apply [redacted] for, (Resident #100), and c.) notify a resident's representative of an injury that occurred at the facility for, (Resident #24). This deficient practice was identified for three (3) of 38 residents reviewed for professional standards of practice related to nursing care. This deficient practice was evidenced by the following:	F 658	F658 Professional Standards What corrective action will be accomplished for those residents affected by the deficient practice? The following residents were identified as being affected by the deficient practice, #41, #100 and #24. • Resident #41 was immediately assessed for [redacted] complications, none noted. [redacted] observation was documented per physician order. • Resident #100 was assessed for skin integrity for signs of [redacted] none	5/22/23

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 _____	04/20/2023

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 658	Continued From page 9 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 casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." 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 licensed practical nurse is defined as performing tasks and responsibilities with in 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." 1.) On 04/06/23 at 10:18 AM, during the initial tour the surveyor observed Resident #41 lying in bed resting with his/her [redacted]. The surveyor reviewed the electronic medical record (EMR) for Resident #41. A review of the resident's Admission Record (AR) reflected that the resident was admitted to the facility [redacted] 22, with diagnoses which included: [redacted] and [redacted] of	F 658	noted. Observed application of [redacted] and documented as per physician order. • Resident #24 family was notified of resident's condition on [redacted]. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the same deficient practice. A facility audit was conducted to identify residents with the following: • [redacted]: The facility identified [redacted] residents who currently have [redacted], no issues noted. The Staff Educator began education on April 14, 2023, to the nursing staff on consistent documentation of observed urine output for residents with [redacted] as ordered by the physician. • [redacted] for [redacted]: The facility identified [redacted] residents who have [redacted], no issues noted. After review of devices, [redacted] residents orders were discontinued due to no longer requiring [redacted] The Staff Educator began education on April 14, 2023, to the nursing staff on following a physician order for application and documentation of [redacted].	

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 _____	04/20/2023

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 658	Continued From page 10 [redacted] A review of the Order Summary Report (OSR) for [redacted] reflected the following: Start Date: [redacted] - Monitor [redacted] every shift and record amount and color every shift. Refer to MD [medical doctor] if [redacted] during shift or change in [redacted] A review of the [redacted] Medication Administration Record (MAR) reflected the following: -The day shift (7:00 AM to 3:00 PM) on 02/17/23, 02/20/23, 02/21/23, 02/24/23, 02/25/23, and 02/28/23 had documented "x" and "9" and the nurses' initials. A review of the [redacted] MAR reflected the following: -The day shift on 03/01/23, 03/02/23, 03/07/23, 03/08/23, 03/10/23, 03/11/23, 03/12/23, 03/14/23, 03/15/23, 03/16/23, 03/20/23, and 03/21/23 had documented "x" and "9" and the nurses' initials. -The day shift on 03/26/23 was left blank. -The evening shift (3:00 PM to 11:00 PM) on 03/12/23, 3/14/23, 3/16/23, and 3/19/23 had documented "x" and "9" and the nurses' initials. -The evening shift on 3/23/23 was left blank. A review of the April 2023 MAR reflected the following: -The day shift on 04/03/23, 04/04/23, 04/05/23,	F 658	• Family notification: All residents have the potential to be affected by the deficient practice. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur? The Director of Nursing and/or designee began re-education on April 14, 2023, to the nursing staff reviewing the following: • Consistent documentation of [redacted] for residents with [redacted] and [redacted]. • Consistently following a physician's order to apply [redacted] for the [redacted]. • Timely notification of resident representative of an injury that occurred at the facility. The Director of Nursing reviewed and began updating the Order Set for residents with [redacted] and [redacted] to reflect the current facility policy. The Unit Manager or Designee will conduct random audits of residents with orders for [redacted] for the [redacted] by rounding and visually observing patients 5 times a week x4 weeks, then 3x a week for four weeks and then weekly for 4 weeks. The Unit Manager or Designee will review incident/accident reports at morning meeting to ensure timely notification of resident representative.	

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 _____	04/20/2023

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 658	Continued From page 11 04/07/23, 04/08/23, 04/09/23, 04/12/23 and 04/13/23 had documented "x" and "9" and the nurses' initials. A review of the Progress Notes (PN) from February 2023 to April 2023 reflected on 02/15/23, Resident #41 was in the hospital from 1/31/23 to 2/15/23. A further review of the PN revealed the nurses documented the [redacted] was patent but did not follow the PO by consistently recording the [redacted] and [redacted] On 04/11/23 at 10:41 AM, the surveyor observed Resident #41 sitting in the [redacted] in the dayroom participating in the activities. On 04/13/23 at 10:51 AM, the surveyor interviewed the Certified Nursing Aide (CNA) who stated that her role included emptying the [redacted] and reporting the amount to the nurse. The CNA stated that she did not have to document the amount in the electronic medical record (EMR) and that the aides only verbally informed the nurses. On 04/17/23 at 09:36 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that the process for caring for residents with a [redacted] included the aides emptying the [redacted] and then would inform the nurse. The LPN stated that the nurses would document the [redacted], the [redacted] and if the [redacted] was [redacted] t and [redacted]. She further stated that nurses documented it every shift in the Medication Administration Record (MAR). The surveyor showed the LPN the MAR and inquired what the "x" and "9" meant in the system. The LPN stated she was not sure what they meant but	F 658	How will the corrective action be monitored to ensure the deficient practice will not recure? The Director of Nursing and/or designee will report the audit results for [redacted] and [redacted], following physician's orders and timely notification of resident representative of an injury that occurred at the facility. The Director of Nursing and/ or designee will report results of the audit to the Quality Assurance Performance Improvement Committee (QAPI) meeting scheduled for May 25th, 2023, and then monthly x3 months. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads.	

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 _____	04/20/2023

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 658	Continued From page 12	F 658		

emphasized she documented Resident #41's [redacted] every shift.

On 04/17/23 at 10:30 AM, the surveyor interviewed an additional LPN working on the unit who stated that the CNAs or the nurses would empty the [redacted]. The LPN stated that if the CNAs emptied it, they would have informed the nurse of the [redacted] and the [redacted] She further stated that the nurses were responsible for documenting it in the EMR. The surveyor inquired about what the "x" and "9" meant on the MAR. The LPN stated she was not sure what they meant. She then stated that they should have been following the PO and documented the [redacted].

On 04/17/23 at 10:32 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) for the [redacted] wing who stated that the CNAs were responsible for emptying the [redacted]. He further stated that the aides then informed the nurses of the [redacted] and the [redacted]. The LPN/UM stated that the nurses were responsible for documenting the [redacted] and the [redacted] in the EMR. The surveyor inquired about the "x" and "9" on the MAR. The LPN/UM stated that meant the resident was unavailable or in the hospital. He then stated that there should be a progress note to reflect that the resident was not in the facility. The LPN/UM stated that Resident #41 was hospitalized but was unable to confirm at that time when the resident was hospitalized. The LPN/UM acknowledged that they should have been following the PO every shift.

On 04/17/23 at 11:05 AM, the surveyor conducted a follow up interview with the same LPN

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 _____	04/20/2023

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 658	Continued From page 13	F 658		

interviewed at 09:36 AM, that same day. The LPN stated that the [redacted] on the MAR meant there was a progress note. The LPN stated that they should have followed the PO every time. She further stated that Resident #41 had [redacted] every shift and acknowledged that she should have documented the [redacted] in the EMR.

On 04/17/23 at 11:12 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the nurses should have been following the PO and documenting it in the EMR. The DON acknowledged that the documentation he provided did not reflect the missing [redacted] on the MAR and progress notes. The DON stated that the nurses should have documented the [redacted] and [redacted] every time. The DON then stated the importance of following the PO was to provide care to the residents. The DON concluded he always told his staff to take credit for what they did because "if it was not documented then it was not done."

On 04/17/23 at 11:39 AM, in the presence of the survey team, the surveyor interviewed the LPN/UM who stated upon his review there was no documentation of the missing [redacted]. He stated that the importance of following the PO was to provide care needed to the residents. The LPN/UM stated that if the [redacted] was not documented then they would not know the [redacted] and if further interventions were needed. He stated that the PO was to monitor the [redacted] and [redacted] and that if there was no [redacted] then the nurses should notify the physician. The LPN/UM stated that Resident #41 had [redacted] every shift and that he also conducted rounds on the residents and monitored the [redacted]. The LPN/UM stated that the "[redacted]" on the MAR reflected

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 _____	04/20/2023

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 658	Continued From page 14	F 658		

to check the progress note but looked and saw that there was no corresponding progress note. He acknowledged that there should have been a progress note or [redacted] documented in the MAR.

A review of the facility's undated policy, [redacted] Utilization Policy/Procedure," included "The [redacted] are to be observed by nursing staff each shift and as needed. Changes are reported to the physician for evaluation/treatment. The [redacted] measuring and documentation is only required when a change is noted and per physician's order, e.g., [redacted] monitoring acute medical condition."

2). On 04/13/23 at 12:53 PM, the surveyor observed Resident #100 in bed with his/her [redacted] the [redacted] and the [redacted] on the [redacted] The resident's [redacted] was [redacted] and the [redacted] was [redacted]. No [redacted] were observed to be worn. The surveyor observed one [redacted] resting on the resident's side table. The resident stated that sometimes the staff put the [redacted] on his/her [redacted].

The surveyor reviewed the EMR for Resident #100.

A review of the resident's AR reflected that the resident was admitted to the facility [redacted] with diagnoses which included: [redacted] and [redacted] on [redacted]) following [redacted] ([redacted]) affecting [redacted] and [redacted]

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 _____	04/20/2023

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 658	Continued From page 15 [redacted]	F 658		

A review of Resident #100's quarterly Minimum Data Set (MDS- an assessment tool utilized to facilitate the management of care) dated [redacted], indicated that the resident scored [redacted] out [redacted] on the Brief Interview for Mental Status (BIMS) score which indicated [redacted] A further review of the resident's MDS revealed that the resident required extensive assistance for [redacted], and [redacted] and that the resident was [redacted]

A review of Resident #100's [redacted] Order Summary Report (OSR) revealed a PO dated [redacted] to apply [redacted] at all times except during hygiene, every shift. A further review of the resident's [redacted] OSR reflected an additional PO dated [redacted] to off load the residents [redacted] when in bed, every shift for preventative skin care.

A review of Resident #100's individualized Care Plan, initiated 1[redacted], revealed an intervention to float the residents [redacted] when in bed and apply [redacted] care products as ordered.

A review of Resident #100's [redacted] Treatment Administration Record (TAR), dated [redacted] - [redacted] revealed the LPN's electronic signature marked in the [redacted] day shift space to apply [redacted] at all times except during hygiene, every shift. A further review of the [redacted] TAR reflected that the LPN electronically signed during the day shift on [redacted] that the resident's [redacted] were [redacted]. A review of the [redacted] TAR contradicted the surveyors observations.

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 _____	04/20/2023

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 658	Continued From page 16 On 04/13/23 at 12:58 PM, the surveyor interviewed the CNA that was assigned to the resident. The CNA stated that she would ask the nurse about the resident's level of assistance and their care and that she was familiar with Resident #100. The CNA stated that Resident #100's [redacted] would stay flat in the bed with a [redacted] under it. When the surveyor and the CNA observed the resident together, the CNA acknowledged that the resident was not wearing [redacted]. The CNA stated that she was unsure if the [redacted] on the side table belonged to the resident and that she had never put [redacted]. When the surveyor inquired about the [redacted] under the resident's [redacted], the CNA stated she would, "just do it so his leg doesn't hit the rail." The CNA acknowledged that the resident's [redacted] was [redacted] on the [redacted] and stated that [redacted] should have been [redacted] on the [redacted]. On 04/13/23 at 01:03 PM, the surveyor interviewed the LPN that was assigned to Resident #100. The LPN stated that she learned how to care for her residents from a verbal report from the previous nurse and also a paper assignment provided at the start of her shift. The LPN stated that she would look in the EMR at the resident's TAR to see if a resident needed some type of device. Together, the surveyor and the LPN looked at the resident's TAR in the EMR. The LPN displayed the TAR and the tasks "Off load heels when in bed" and "Apply [redacted] at all times except for hygiene" were displayed in [redacted]. When the surveyor inquired what the [redacted] represented, the LPN stated that the task would turn [redacted] when the tasks were marked by the nurse as completed.	F 658		

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 _____	04/20/2023

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 658	Continued From page 17	F 658		

At that time, the surveyor and the LPN observed Resident #100 in bed. The LPN acknowledged that the resident was not having hygiene at that time and that the resident's [redacted] were directly on the [redacted] and stated that the resident's [redacted] should have been elevated. The LPN placed the [redacted] on the resident's [redacted] and stated, "In my opinion as long as the [redacted] is on the [redacted] then [redacted] does not need both [redacted]." The LPN then stated that it was important to follow the PO and that she should have elevated both [redacted] off of the bed to prevent [redacted], [redacted] and [redacted]. The surveyor then observed the LPN obtain a [redacted] from the closet. The LPN removed the [redacted] from the resident's [redacted] and placed it on the resident's [redacted]. The LPN then placed the [redacted] on the resident's right foot. When the surveyor inquired about the LPN signing off the [redacted] and the [redacted] the resident's [redacted] on the TAR, the LPN acknowledged that she signed the TAR as completed without knowing if the tasks were actually done. The LPN stated that she should not have signed the tasks as completed before they were done and that it was important to follow the PO correctly to make sure everything was completed as ordered.

On 04/14/23 at 11:31 AM, the surveyor interviewed the (LPN/UM) about Resident #100. The LPN/UM stated that the resident had [redacted] to keep his/her [redacted] and that they were to be worn in bed at all times. Together, the surveyor and the LPN/UM reviewed the resident's TAR in the EMR. The LPN/UM acknowledged the PO for [redacted] at all times except during hygiene and for [redacted] while in bed and

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 _____	04/20/2023

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 658	Continued From page 18	F 658		

stated that when the order was obtained that it went on the TAR and that would have been how the nurse knew to complete the task. The LPN/UM acknowledged that once the task was completed that the display [redacted]. The surveyor informed the LPN/UM of the observation of the resident with the LPN and the task being marked as completed in the EMR. The LPN/UM stated that the TAR should not have been marked as completed if the [redacted] were not worn or the [redacted] were not [redacted]. The LPN/UM further stated that it was important to wear the [redacted] to prevent [redacted] and that the PO should have been followed for continuity of care.

On 04/14/23 at 11:50 AM, the surveyor interviewed the DON about Resident #100. Together, the surveyor and the DON reviewed Resident #100's TAR in the EMR. The DON stated that if there was a PO, the expectation was for the staff to follow the order and that if the order was displayed as [redacted] that it meant that the nurse saw the order and marked that it was done. The surveyor informed the DON of the observation of the resident with the LPN and the tasks being marked as completed in the EMR. The DON acknowledged that the nurse did not follow the order correctly and that she should have looked at the treatment first, put the [redacted] on, made sure that the resident's [redacted] and then signed off on the TAR. The DON stated that it was important to off load the resident's [redacted] for basic skin prevention and that the doctor's order was not followed.

A review of the facility's undated policy, "Treatment and Medication Pass Documentation, POC (Electronic Medical Record), revealed,

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 _____	04/20/2023

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 658	Continued From page 19	F 658		

Procedure: 1.Treatment and Medication Pass EMR Documentation, B ...The entering, verification, activation, and signing of orders in the EMR is through an electronic signature which is unique for each authorized EMR user. G. Medication Administration and Treatment Documentation, Med Pass and Treatment documentation will be on Point Click Care for all licensed staff.

3.) On 04/06/23 at 11:58 AM, the surveyor conducted an interview over the telephone with Resident #24's resident representative who stated that the resident at one time had [redacted] his/her [redacted] at the facility and the facility did not call the resident representative to notify him/her of the [redacted] and the scheduled doctor's appointment due to the [redacted]. The resident representative stated that he/she, "was not happy about this".

On 04/11/23 at 11:58 AM, the surveyor observed Resident #24 self-propelling throughout the unit in his/her wheelchair. The resident was observed with his/her [redacted] positioned on their [redacted] and was using their feet to quickly travel throughout the unit.

On 04/14/23 at 11:27 AM, the surveyor observed the resident self-propelling out of their room in his/her wheelchair. The resident was observed with his/her [redacted] in their [redacted] and was quickly moving their feet to obtain speed while moving throughout the unit.

The surveyor reviewed the EMR for Resident #24.

A review of the resident's Admission Record (an

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 _____	04/20/2023

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 658	Continued From page 20 Admission Summary) reflected that the resident had resided at the facility since [redacted] and had diagnoses which included but were not limited to [redacted] A review of the resident's quarterly MDS, dated [redacted], revealed that the resident had a BIMS score of [redacted] which indicated the resident had [redacted]. A review of the facility's Incident Report dated [redacted] and timed at 14:20 (2:20 PM) indicated that a facility staff member observed bruising to the resident's [redacted], and the resident complained of [redacted] to the area. The Incident Report indicated that the resident was unable to give a description of how the injury occurred. A [redacted] was applied to the resident's [redacted] and an immediate [redacted] was taken of the resident's [redacted]. Additional information included in the Incident Report revealed that the resident was independently mobile when in wheelchair, had very [redacted] and had a history of [redacted]. The Incident Report further provided information that the resident self propelled his/her wheelchair with their feet out and reached out at objects while the wheelchair was in motion. The Incident Report indicated that no people were notified that the resident had injured his/her [redacted]. A review of the DONs Findings and Conclusion of the event indicated that an [redacted] was ordered	F 658		

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 _____	04/20/2023

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 658	Continued From page 21	F 658		

which revealed a [redacted] of the residents [redacted] and the most plausible causative factor of the injury was that the resident had [redacted] with a history of wheeling himself/herself into [redacted], and the injury was self-inflicted.

A review of the resident's Progress Notes (PN) dated [redacted] and timed at 12:44 PM, authored by the DON revealed, "Asked to see resident's [redacted]. [Resident's name redacted] is in [his/her] room sitting in [his/her] wheelchair. [He/she] is [redacted] [his/her] usual self. Noted bruising to the [redacted], and [redacted] along the [redacted] noted at this time. No visible [redacted] /injury to the [redacted]. [redacted] is [redacted] with [redacted] of [redacted]. Per assessment, patient complains of [redacted] even with [redacted] along the [redacted] but none even with ranging of [redacted]. [Resident's name redacted] is not able to verbalize cause of bruise due to [redacted]. [He/She] does wheel [himself/herself] independent in and out of unit." The PN does not indicate that a family member was notified of the incident.

A further review of the resident's PN reflected a PN written by the resident's LPN dated [redacted] and timed at 15:20 (3:20 PM). The PN indicated that the resident's representative came into the facility to visit the resident and expressed concern about not being made aware of the resident's [redacted] and scheduled doctor's appointment for the [redacted].

On 04/12/23 at 10:26 AM, the surveyor

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 _____	04/20/2023

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 658	Continued From page 22	F 658		

interviewed the resident's CNA who stated that the resident was alert [redacted] and was able to make his/her needs known. The CNA further stated that the resident self-propelled around the unit in his/her wheelchair, could open his/her [redacted] and the resident's [redacted]. The CNA told the surveyor that she remembered that the resident had a history of a [redacted] and if she identified that a resident had [redacted], [redacted], she would notify the nurse and write a statement as to what she had observed. The CNA did not speak to notification of the resident's representative

On 04/12/23 at 10:29 AM, the surveyor interviewed the resident's LPN who stated that the resident had [redacted], [redacted] care at times, was easy to re-direct, and would self-propel throughout the unit in his/her wheelchair. The LPN stated that she recalled when Resident #24 [redacted] his/her [redacted]. The LPN stated that part of the incident investigative process was to notify the family of the incident.

On 04/12/23 at 10:34 AM, the surveyor interviewed the LPN/UM who stated that he had been working at the facility for two (2) months, so he was not at the facility when the resident broke his/her [redacted]. The LPN/UM spoke to the investigative process which included getting statements from facility staff, notifying the resident's physician and resident representative.

On 04/12/23 at 10:41 AM, the surveyor interviewed the facility's Social Worker (SW) who stated that if a resident had an injury, it was the facility's practice to call the resident's representative and notify them of the injury and

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 _____	04/20/2023

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 658	Continued From page 23 the continuation of care that was to be provided to the resident. On 04/12/23 at 10:56 AM, the surveyor interviewed the DON who stated that it was the facility's protocol to notify the family (resident representative) if a resident obtained an injury at the facility. On 04/12/23 at 11:03 AM, the surveyor interviewed the facility's Licensed Nursing Home Administrator (LNHA) who stated that if a resident had an injury at the facility the family, guardian or responsible party would be notified of the event. A review of the facility's undated policy, "Incident, Accident Investigation and Reporting Policy and Procedure," indicated that incidents or accidents included but were not limited to falls and injuries and the resident's responsible party and family would be made aware of all incident and accidents investigations.	F 658		
F 661 SS=E	NJAC 8:39-27.1 (a)(b) Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for	F 661		5/22/23

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 _____	04/20/2023

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 661	Continued From page 24 release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documentation it was determined the facility failed to ensure discharge summaries were documented which included a recapitulation (recap) of the resident's stay and a final summary of the resident's status for five (5) of five (5) residents (Resident #29, #123, #325, #326, and #327) reviewed for discharge. This deficient practice was evidence by the following: 1.) On 04/06/23 at 10:02 AM, during the initial tour, the surveyor observed Resident #29 sitting in his/her wheelchair watching television in their room. Resident #29 stated that he/she might be discharged on [redacted] due to insurance issues but was not completely sure.	F 661	Discharge Summary F661 SS=E What corrective action will be accomplished for those residents affected by the deficient practice? Residents #29, #123, #325, #326, #327 were identified to be affected by the deficient practice. All residents identified have been discharged from the facility. The Director of Nursing provided 1:1 education on April 27, 2023, to the identified physician regarding timely documentation and a discharge summary for scheduled patient discharges. How will the facility identify other residents having the potential to be affected by the same deficient practice and what	

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 _____	04/20/2023

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 661	Continued From page 25 The surveyor reviewed the electronic medical record (EMR) for Resident #29. A review of the resident's Admission Record (AR) reflected that the resident was initially admitted to the facility in [redacted] and readmitted [redacted], with diagnoses which included: [redacted]. A review of an unsigned Patient Discharge Instructions revealed the resident was discharged on [redacted]. A review of the [redacted] Progress Notes (PN) reflected the following: -On [redacted] at 17:47 (5:47 PM), the PN indicated that Resident #29 was scheduled to be discharged home with their family tomorrow [redacted] at 12 PM. A Review of the April Order Summary Report (OSR) did not reflect a Physician Order (PO) for discharge. On 04/11/23 at 11:31 AM, the surveyor interviewed the Agency Licensed Practical Nurse (A/LPN) who stated that today was only her third time at the facility. She stated she never discharged a resident at this facility but could speak to the, "normal" process for discharging a resident. The A/LPN stated that the process would have been to go over the paperwork and medications, check the resident's vital signs, ensure the resident signed the discharge instructions and then document it in the medical	F 661	corrective action will be taken? All residents have the potential to be affected by the same deficient practice. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur? On April 11, 2023, the Staff Educator provided education to the nursing staff on the need for timely discharge documentation. On April 27, 2023, the Director of Nursing educated the facility physicians on the need for timely documentation and a discharge summary for scheduled patient discharges. The Unit Managers or designee will audit all discharges for 3 months to ensure timely nurse and physician documentation and a physician discharge summary for scheduled patient discharges. How will the corrective action be monitored to ensure the deficient practice will not recure? The Director of Nursing and/or designee will report the audit results during the Quality Assurance Performance Improvement (QAPI) meeting scheduled for May 25th, 2023, and then monthly x3 months. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and department heads.	

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 _____	04/20/2023

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 661	Continued From page 26	F 661		

record on what time the resident left the facility and who they left with. The A/LPN stated that they needed a PO to discharge the resident and that the discharge summary should have been documented in the medical record.

On 04/11/23 at 11:41 AM, the surveyor interviewed the LPN/Unit Manager (LPN/UM) for the A Wing who stated that the process for discharge was that during the Interdisciplinary Team (IDT) meeting the team would discuss tentative dates for the resident's discharge. He stated that then the resident's Primary Care Physician (PCP) was informed of the tentative date, so that the PCP could have prepared the discharge instructions and placed it in the hard chart if it was completed ahead of time. The LPN/UM further stated they did not need to obtain a PO to discharge the resident. He stated that the PCPs completed the discharge summary the day of the discharge or whenever they came into the facility. He explained to the surveyor the PCPs did not have set days when they came into the facility and could not speak to how often they came into the facility. The LPN/UM explained that during the day of discharge the nurse went over the discharge instructions with the resident and ensured that the resident signed and understood the instructions. He stated that Resident #29 was discharged over the weekend. The surveyor asked if the process was the same over the weekend? The LPN/UM replied, "yes". He stated that the nurse should still have put in a discharge note even if it was over the weekend. The LPN/UM reviewed the EMR with the surveyor and confirmed that at that time there was no discharge note from the nurse and no discharge summary from the PCP. He acknowledged that a discharge note should have been completed.

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 _____	04/20/2023

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 661	Continued From page 27	F 661		

On 04/11/23 at 12:08 PM, the surveyor interviewed the Director of Nursing (DON) who stated that during the IDT meetings they discussed the potential discharges. The DON stated that they then informed the PCP so that they could obtain a PO and the prescriptions for discharge. The DON stated that Social Services started the process first because sometimes there were issues with the insurance companies such as with Resident #29. He further stated that the PCP would come into the facility to see the resident and wrote the prescriptions for discharge. The DON explained the PCP wrote the discharge order and if they had time then they completed the discharge summary at the time of the visit. He further explained that if the discharge was short notice, then the nurses were assured that they had an order for discharge and the prescriptions for the resident prior to discharge. The DON stated that the nurse was also responsible for going over the discharge instructions with the resident, which was typically done the day of discharge. He stated that prior to the resident being discharged the nurse took the resident's vital signs to ensure that the resident was being discharged in a stable condition. The DON stated that all discharge information should have been documented in the EMR. He stated that because they used agency staff, they sometimes did not document in the EMR. The DON acknowledged that there should have been a discharge PO as well as a discharge summary from the physician and a discharge PN from the nurse.

On 04/11/23 at 12:16 PM, the surveyor continued to interview the DON who stated that some of the physicians did not come to the facility on a regular

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 _____	04/20/2023

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 661	Continued From page 28	F 661		

basis. He stated it depended on the group because the Medical Doctor's group came more frequently. He further stated that PCP #1 did not come as frequently but was available by phone.

On 04/11/23 at 12:36 PM, the surveyor interviewed PCP #1 via the telephone who stated the process for discharge was that he would be notified by the facility of the potential discharge. He stated that he would then come into the facility and write the prescriptions and filled out anything the resident needed. He further stated that he would then visit with the resident and used a medical scribe service (an allied health paraprofessional who specializes in charting physician-patient encounters in real time, such as during medical examinations) that wrote his notes which were then transferred to the EMR. PCP #1 stated that it had been taking the medical scribe service about three (3) days to complete the transcription before he transferred it into the EMR. He further stated it currently took the three days because the service was currently behind. The surveyor asked PCP #1 if he saw Resident #29 for discharge? PCP #1 stated that his Nurse Practitioner (NP) "saw the resident probably the night before [redacted] the resident was discharged." PCP #1 stated that Resident #29 was a unique situation as the resident had been waiting on an insurance appeal. He stated that the appeal was declined, and Resident #29 was discharged. PCP #1 stated that his NP used the medical scribe service as well for documentation. The surveyor asked PCP #1 if a PO was required to discharge a resident from the facility? PCP #1 stated that he did not have to write a discharge PO because he was writing the prescriptions which would have been considered the discharge PO.

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 _____	04/20/2023

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 661	Continued From page 29	F 661		

On 04/11/23 at 12:40 PM, the surveyor continued to interview PCP #1 who stated that he came to the facility two (2) to three (3) times a week. He stated that his NP only came as needed in situations where he was unable to come to the facility. PCP #1 stated that the last time he was in the facility was on [redacted], but was unable to confirm another day that week that he came to the facility. PCP #1 again stated that he typically did not write a discharge order because he wrote the prescriptions which reflected that the resident would have been getting discharged.

On 04/11/23 at 01:05 PM, in the presence of the survey team, the LPN/UM stated that it was an agency nurse that discharged Resident #29. At that time, the LPN/UM provided a copy of the discharge instructions provided to Resident #29. The LPN/UM stated that the agency nurse did not make a copy of the discharge instructions that reflected both the nurse and residents' signatures. He stated that because it was an agency nurse that discharged Resident #29, another nurse (LPN #1) that was at the facility at the time of discharge entered a late entry discharge note in the EMR after surveyor inquiry. The LPN/UM acknowledged the discharge PN should have been completed at the time of discharge.

On 04/11/23 at 01:31 PM, in the presence of the survey team and the DON, the Licensed Nursing Home Administrator (LNHA) stated that the expectations were that the discharge summary should have been completed upon discharge. She further stated that documentation in the form of a PN from social services, the nurses, and the physicians should have been completed as well.

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 _____	04/20/2023

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 661	Continued From page 30 A further review of the [redacted] PN for Resident #29 revealed the following: -Effective date [redacted] at 15:47 (3:47 PM); Created date [redacted] at 15:47 by PCP #1 indicated: "Tentative discharge end of week to home with [redacted] " -Effective date [redacted] at 09:01 (9:01 AM); Created date [redacted] at 09:02 (9:02 AM) by PCP #1 indicated: Discharge Summary - "Resident seen for discharge. Patient seen today in room. Stable for discharge with services." -Effective date [redacted] at 13:30 (01:30 PM); Created [redacted] at 12:46 (12:46 PM) from LPN #1 indicated: "Resident's [family member] came and p/u [pick-up] resident for discharge, resident is stable, resident was discharged home." - There were no discharge summaries from the nurses nor from the attending physician until after surveyor inquiry. On 04/12/23 at 10:14 AM, the surveyor and the DON reviewed the EMR together as the surveyor inquired about the discharge summary from the NP for Resident #29. The DON stated he could not find a discharge summary from the NP. The DON stated that he was unable to confirm if the NP discharged Resident #29 because he was not sure of the last time that the resident was seen by the NP. At that time, the DON confirmed that there was no discharge PO, physician's discharge summary and no nurse's PN until after surveyor inquiry. The DON stated that it was not best practice and that it should have been done prior to surveyor inquiry.	F 661		

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 _____	04/20/2023

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 661	Continued From page 31 2.) The surveyor reviewed the EMR for Resident #123. A review of the resident's AR reflected that the resident was admitted to the facility [redacted] with diagnoses which included: [redacted]. A review of the [redacted] PN reflected the following: - On [redacted] the resident was discharged with family. -Effective [redacted] at 10:03 AM; created 2/3/23 at 10:04 AM by PCP #1 indicated: Patient seen for discharge. Patient for discharge in two (2) days. A further review of the [redacted] PN revealed there was no discharge summary from the PCP. A review of the [redacted] OSR did not reflect a PO for discharge. 3.) The surveyor reviewed the EMR for Resident #325. A review of the resident's AR reflected that the resident was admitted to the facility [redacted], with diagnoses which included: [redacted]. A review of the [redacted] PN reflected the following:	F 661		

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 _____	04/20/2023

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 661	Continued From page 32 - On [redacted] the resident was discharged home with family. -Effective [redacted] at 10:59 AM; created [redacted] at 10:59 AM by PCP #1 indicated: Patient seen for follow up of [redacted] A further review of the [redacted] PN revealed there was no discharge summary from the PCP. A review of the [redacted] OSR did not reflect a PO for discharge. 4.) The surveyor reviewed the EMR for Resident #326. A review of the resident's AR reflected that the resident was admitted to the facility [redacted], with diagnoses which included: [redacted]. A review of the [redacted] PN reflected the following: - On [redacted] the resident was discharged with a family member. -Effective [redacted] at 10:12 AM; created [redacted] at 10:12 AM by PCP #1 indicated: Respite Admission. A further review of the [redacted] PN revealed there was no discharge summary from the PCP. A review of the [redacted] OSR did not reflect a PO for discharge. 5.) The surveyor reviewed the EMR for Resident	F 661		

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 _____	04/20/2023

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 661	Continued From page 33 #327. A review of the resident's AR reflected that the resident was admitted to the facility [redacted], with diagnoses which included: [redacted]. A review of the [redacted] PN reflected the following: - On 1[redacted] the resident was discharged to another facility. -Effective [redacted] at 09:57 AM; created 12/6/22 at 09:58 AM by PCP #1 indicated: Patient seen for follow up of [redacted]. A further review of the [redacted] PN revealed there was no discharge summary from the PCP. A review of the [redacted] OSR did not reflect a PO for discharge. On 04/14/23 at 01:11 PM, in the presence of the LNHA, the Infection Preventionist (IP) and the survey team, the DON stated that the expectations for physicians that utilized the medical scribe service was that the physician should have uploaded the information within a few hours after they assessed the resident. He further stated that the expectations were for the physician to have assessed the resident and documented that day. The DON stated that it was important for the information to be uploaded within a few hours was so that they knew a physician followed up with that resident and so that staff were aware of that assessment and	F 661		

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 _____	04/20/2023

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 661	Continued From page 34	F 661		

provided the appropriate care.

On 04/14/23 at 01:13 PM, in the presence of the DON, IP, and the survey team, the LNHA stated that the expectations of the physician were for them to see and assess the resident, ensure that the recommendations were reviewed and carried out if appropriate. She stated that it was important because it ensured that the physicians and the nursing staff cared for the residents.

On 04/14/23 at 01:19 PM, the surveyor interviewed the DON again regarding the time length it took for the medical scribe service to be uploaded into the EMR. The DON could not speak to how long it took.

On 04/17/23 at 01:14 PM, in the presence of the survey team, the LNHA confirmed upon review that there was no discharge summary for Residents #123, #325, #326, and #327. The LNHA acknowledged that there should have been a discharge summary. The LNHA stated that she was not sure how long it took for the medical scribe service to upload. She further stated that the physician's discharge summary should have been completed within three days. The LNHA stated that the facility did not have a specific policy to reflect the time frame for when the discharge summary should have been completed. The LNHA again acknowledged a physician's discharge summary should have been done.

On 04/19/23 at 11:17 AM, the survey team interviewed PCP #1, via telephone, who stated that he utilized two (2) Registered Nurses (RN) who typed his notes for him to be uploaded into the EMR. PCP #1 stated that he was not aware of

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 _____	04/20/2023

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 661	Continued From page 35	F 661		

the federal regulation of when the medical records should have been completed.

On 04/19/23 at 11:29 AM, the survey team continued to interview PCP #1 regarding who saw Resident #29 prior to discharge. He stated that the NP saw the resident the day of discharge [redacted]), but he could not speak to if she wrote a PN reflecting the physician visit. He stated that the PN he wrote was the last time he saw the resident. PCP #1 stated that the expectations for PN were that they should have been completed within a few days. The surveyor informed PCP #1 of the multiple late entries and PCP #1 stated that he "never put in late notes" and never as late as those that were reviewed with him over the phone for Residents #123, #325, #326, and #327. He then stated that the PN should have been "entered right away". PCP #1 stated that as soon as he found out a resident was in the process of being discharged, that he came to the facility to see the resident, wrote the prescriptions, and then wrote a PN. He then stated that if he saw the resident the day of them being discharged then he wrote a discharge PN but that if he did not see the resident the day of the discharge then he did not write a discharge PN. PCP #1 stated that he did not know that he had to write a discharge summary for the resident once they were discharged.

On 04/19/23 at 11:59 AM, the survey team interviewed the Medical Director (MD) for the facility, via telephone, who stated that the physician's discharge summary should have been completed within a timely manner after the assessment of the resident to ensure the facility complied with the federal regulations. The MD stated that the physician was responsible for

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 _____	04/20/2023

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 661	Continued From page 36 completing the discharge summary because they had to "close out a chart." The MD emphasized there should have been a discharge summary somewhere in the chart. He stated that a PO was required to discharge the resident from the facility. On 04/20/23 at 09:31 AM, in the presence of the DON and the survey team, the LNHA acknowledged that if something was not documented that it was not done. A review of the facility's policy, "Discharge of a Patient," revised 04/20/23, included, "7. The attending physician will be notified and a discharge order will be obtained by nursing .....12. Nursing discharge documentation will include but not limited to: patient condition on day of discharge, review and understanding of discharge instructions ..." A review of the facility's policy, "Physician Services," revised April 2013, included, "4. Physician orders and progress notes shall be maintained in accordance with current OBRA [Omnibus Budget Reconciliation Act] regulations and facility policy." NJAC 8:39-35.2(d)(16)	F 661		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		5/22/23

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 _____	04/20/2023

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 684	Continued From page 37 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation it was determined that the facility failed to: a.) ensure a resident who had multiple clinical diagnoses received their medications to treat their clinical diagnoses in accordance with physician prescribed orders consistently over a two month time frame, b.) ensure a resident received their medications in accordance with manufacturer specifications and c.) follow their medication administration policy and procedure. This deficient practice was identified for one (1) of 38 residents, (Resident #35), reviewed for quality of care and was evidenced by the following: Refer to F697H On 04/06/23 at 12:35 PM, Surveyor #1 observed Surveyor #2 talking to Resident #35 at the end of the hallway on the [redacted] unit. Surveyor #1 overheard the resident tell Surveyor #2 that he/she had not received any of his/her medications that day. At that time, Surveyor #1 observed Surveyor #2 walk toward the Licensed Practical Nurse/Acting Unit Manager's (LPN/AUM) office to notify the facility staff member that Resident #35 was requesting his/her medications. On 04/06/23 at 12:36 PM, Surveyor #1 walked down the end of the hallway toward Resident #35 and observed the resident seated in his/her wheelchair. The resident stopped the surveyor and stated that he/she had not received their	F 684	QUALITY OF CARE F684 SS=E What corrective action will be accomplished for those residents affected by the deficient practice? Resident #35 was immediately provided with the physician ordered scheduled medications. The Director of Nursing provided 1:1 education to the administering nurse on April 6, 2023, regarding timely administration of medications as ordered by the physician and according to manufacturer's specifications. The Pharmacy Consultant conducted a medication pass observation to the administering nurse on April 10, 2023, with satisfactory performance. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the same deficient practice. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur?	

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 _____	04/20/2023

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 684	Continued From page 38 medications that day. The resident further stated, "I don't know why they haven't given me my medications." On 04/06/23 at 12:40 PM, Surveyor #1 interviewed the LPN/AUM at the medication cart in front of the nurse's station. The surveyor asked the LPN/AUM if Resident #35 had received his/her medications. The LPN/AUM stated that she had just taken the resident's [redacted] because the resident was on a [redacted] medication, and she was going to administer the resident's medications now. On 04/06/23 from 12:40 PM to 12:46 PM, Surveyor #1 stood at the nurse's station, next to the medication cart and observed the LPN/AUM gather the resident's medications, walk down the hallway, and administer medications to Resident #35. On 04/06/23 at 12:48 PM, the surveyor reviewed Resident #35's [redacted] 3 Medication Administration Record (MAR) on the computer attached to the medication cart in the presence of the LPN/AUM. At that time, Surveyor #1 identified that the resident had not received his/her 8:00 AM and 9:00 AM routine scheduled medications which included [redacted] medications, vitamins, medications to alleviate constipation, and medications to treat [redacted] Surveyor #1 asked the LPN/AUM what medications she had administered to the resident and the LPN/AUM stated that she had just administered all the resident's 8:00 AM and 9:00 AM physician prescribed medications and "normally would not have administered them this late." Surveyor #1 asked the LPN/AUM what happened, and the LPN/AUM stated that she was	F 684	The Director of Nursing and/or designee began re-education of nursing staff on April 18th, 2023 regarding timely administration of medications as ordered by the physician and according to manufacturer's specifications. Unit Managers and or designee will audit the timeliness of medication pass 5 times a week x4 weeks, then 3x a week for four weeks and then weekly for 4 weeks. Pharmacy Consultant is scheduled on May 15th, 2023, to begin conducting medication pass observation on the nursing staff. The results of the medication pass will be provided to the Director of Nursing for review during clinical morning meetings. How will the corrective action be monitored to ensure the deficient practice will not recure? The Director of Nursing and/ or designee will report results of the audits to the Quality Assurance Performance Improvement Committee (QAPI) meeting scheduled for May 25th, 2023, and then monthly x3 months. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director, and Department Heads.	

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 _____	04/20/2023

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 684	Continued From page 39	F 684		

caring for other residents, it was an oversite, and there were other nurses available that could have helped her. The LPN/AUM told Surveyor #1 that she had one hour before and one hour after to administer the resident his/her medications. The LPN/AUM stated that she had just administered the resident's [redacted] medication [redacted] that should have been administered with food, but the resident was going to receive his/her lunch soon.

On 04/06/23 at 01:26 PM, Surveyor #1 interviewed the resident's Certified Nursing Aide (CNA) who stated that he had cared for Resident #35 about four (4) or five (5) times prior and had the resident on his assignment that day. The CNA told the surveyor that the resident was [redacted]t and could make needs known. The CNA further gave the example that the resident was able to verbalize that he/she needed to be dressed slowly and carefully to avoid pain. The CNA explained that he had cared for the resident earlier that day around 9:45 AM - 10:00 AM and at that time the resident did not mention to him that she had not received her medications.

On 04/06/23 at 01:46 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA) who stated that medications should be administered as ordered by the physician and the nurse had one hour before and one hour after to administer the resident their medications. The DON told the surveyor that he was familiar with Resident #35 and the resident recently had healed from a [redacted] illness, had a past medical history of a [redacted]

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 _____	04/20/2023

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 684	Continued From page 40 On 04/11/23 at 11:29 AM, Surveyor #1 interviewed the facility's Consultant Pharmacist (CP) over the telephone. The CP stated that medications were required to be administered one hour before and one hour after the physician prescribed the medication. The CP further stated that the medication, [redacted] was supposed to be administered with food because it helped with the absorption of the medication. On 04/12/23 at 11:09 AM, Surveyor #1 conducted a follow up interview with the DON who stated that he had reviewed Resident #35's [redacted] and [redacted] Medication Administration Audit Report (MAAR) and had identified that the nurses had not been administering Resident #35's medications on time as prescribed by the physician. On 04/18/23 at 09:47 AM, Surveyor #1 interviewed the resident's Primary Care Physician (PCP) who stated that when a resident had a physician order (PO) for a medication, the medication should have been administered within one hour before and one hour after the scheduled administration time. Surveyor #1 asked the PCP why administering scheduled [redacted] medication was important if a resident had diagnoses that supported [redacted]? The PCP told the surveyor that it was important to administer the pain medication on time and appropriately to manage the resident's [redacted] and keep the resident's [redacted] at a [redacted] that was [redacted]". The PCP further stated that the medication, [redacted] was supposed to be administered with food because food helped the body absorb the medication. The surveyor reviewed the medical record for	F 684		

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 _____	04/20/2023

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 684	Continued From page 41 Resident #35. A review of the resident's Admission Record (an Admission Summary) reflected that the resident was a long term care resident at the facility and had diagnoses which included but were not limited to [redacted]. A review of the resident's quarterly Minimum Data Set (MDS- an assessment tool used to facilitate the management of care) dated [redacted] indicated the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident's cognition was [redacted]. A review of the [redacted] Order Summary Report (OSR) revealed the following PO's: -PO dated [redacted] for the medication, [redacted] 5 milligrams (mg), give [redacted] table by mouth one time a day for [redacted]. -PO dated [redacted] for the medication, [redacted] tablet [redacted] mg-unit, give	F 684		

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 _____	04/20/2023

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 684	Continued From page 42 [redacted] tablet by mouth [redacted] times a day related to [redacted]. -PO dated [redacted] for the medication, [redacted] mg, give [redacted] tablet by mouth [redacted] times a day for [redacted] -PO dated [redacted] for the medication, [redacted], apply to [redacted] topically one time a day for [redacted]. Remove patch at bedtime and remove per schedule. -PO dated [redacted] for the medication, [redacted] powder [redacted]-gram (gm) [redacted], give one [redacted] by mouth one time a day for [redacted]. -PO dated [redacted] for the medication, [redacted], give [redacted] capsule by mouth [redacted] time a day for times days. -PO dated [redacted] for the medication, [redacted] gm, give [redacted] tablet by mouth two times a day for [redacted] -PO dated [redacted] for the medication, [redacted] mg, give [redacted] tablet by [redacted] times a day for [redacted] at 8:00 AM, 2:00 PM, and 8:00 PM. -PO dated [redacted] for the medication, [redacted] microgram, give [redacted] tablet by mouth one time a day for [redacted]. A review of the [redacted] Medication Administration Record (MAR) indicated that the nurses were signing for the administration of the following medications:	F 684		

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 _____	04/20/2023

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 684	Continued From page 43 - [redacted] mg by mouth [redacted] time a day at 0900 (9:00 AM). - [redacted] apply topically to [redacted] one time a day at 0900. - [redacted]-gram (gm) [redacted], give one [redacted] by mouth one time a day at 0900. - [redacted], give one capsule by mouth one time a day at 0900. - [redacted] [redacted]gm, give [redacted] tablet by mouth two times a day at 0900 and 1700 (5:00 PM). - [redacted]microgram (mcg), give one tablet by mouth one time a day at 0900. - [redacted] tablet [redacted] mg-unit, give [redacted] tablet by mouth [redacted] times a day at 0900 and 1700 (5:00 PM). - [redacted] mg, give [redacted] tablet by mouth [redacted] times a day for [redacted] at 0800 (8:00 AM) and 1700. [redacted] - [redacted] mg, give [redacted] tablet by mouth [redacted] times a day for [redacted] at 8:00 AM, 2:00 PM, and 8:00 PM. A review of the [redacted] OSR revealed the following PO's: -PO dated [redacted] for the medication, [redacted] tablet [redacted] milligrams (mg)-unit, give [redacted] tablet by mouth [redacted] times a day related to [redacted].	F 684		

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 _____	04/20/2023

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 684	Continued From page 44 -PO dated [redacted] for the medication, [redacted] mg, give [redacted] tablet by mouth [redacted] times a day for [redacted] n. [redacted] -PO dated [redacted] for the medication, [redacted] apply to [redacted] topically one time a day for [redacted]. Remove patch at bedtime and remove per schedule. -PO dated [redacted] for the medication, [redacted] -gram (gm) [redacted], give one [redacted] by mouth one time a day for [redacted] -PO dated [redacted] for the medication, [redacted], give [redacted] capsule by mouth one time a day for [redacted]) for ten (10) days. -PO dated [redacted] for the medication, [redacted] gm, give [redacted] tablet by mouth two times a day for [redacted]). -PO dated [redacted] for the medication, [redacted] mg, give [redacted] tablet by mouth [redacted] times a day for [redacted] at 8:00 AM, 2:00 PM, and 8:00 PM. -PO dated [redacted] for the medication, [redacted] mcg, give [redacted] tablet by mouth one time a day for [redacted]. A review of the [redacted] MAR indicated that the nurses were signing for the administration of the following medications. -[redacted] apply topically to [redacted] one time a day at 0900.	F 684		

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 _____	04/20/2023

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 684	Continued From page 45 [redacted] gram (gm) [redacted], give one [redacted] by mouth one time a day at 0900. - [redacted] Capsule, give one capsule by mouth one time a day at 0900. - [redacted] gm, give [redacted] tablet by mouth [redacted] times a day at 0900 and 1700. - [redacted] mcg, give [redacted] tablet by mouth one time a day at 0900. - [redacted] mg-unit, give [redacted] tablet by mouth [redacted] times a day at 0900 and 1700. - [redacted] mg, give [redacted] tablet by mouth two times a day for [redacted] at 0800 and 1700. [redacted] - [redacted] mg, give one tablet by mouth [redacted] times a day for [redacted] pain at 8:00 AM, 2:00 PM, and 8:00 PM. A review of the [redacted] MAAR revealed the following: -On [redacted], [redacted] mg was administered at 9:48 AM. Forty-eight (48) minutes late. -On 03/01/23, [redacted] mg was administered at 9:47 AM. Forty-seven (47) minutes late. -On 03/03/23, [redacted] mg was administered at 10:25 AM. One (1) hour and twenty-five (25) minutes late.	F 684		

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 _____	04/20/2023

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 684	Continued From page 46 -On [redacted] mg was administered at 10:31 AM. One (1) hour and thirty-one (31) minutes late. -On [redacted] mg was administered at 10:31 AM. Thirty-one (31) minutes late. -On [redacted] tablet [redacted] mg-unit was administered at 10:30 AM. Thirty (30) minutes late. -On [redacted] was administered at 10:31 AM. Thirty-one (31) minutes late. - On [redacted] mcg was administered at 10:30 AM. Thirty (30) minutes late. -On [redacted] gm [redacted] was administered at 10:31 AM. Thirty-one (31) minutes late. -On [redacted] mg was administered at 10:35 AM. One (1) hour and thirty-five (35) minutes late. -On [redacted] mg was administered at 10:36 AM. One (1) hour and thirty-six (36) minutes late. -On [redacted] mg was administered at 10:36 AM. Thirty-six (36) minutes late. -On [redacted] tablet [redacted] mg-unit was administered at 10:36 AM. Thirty-six (36) minutes late. -On 03/05/23, [redacted] gm [redacted] was	F 684		

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 _____	04/20/2023

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 684	Continued From page 47 administered at 10:36 AM. Thirty-six (36) minutes late. -On [redacted] mcg was administered at 10:37 AM. Thirty-seven (37) minutes late. -On [redacted] was administered at 10:38 AM. Thirty-eight (38) minutes late. -On [redacted] mg was administered at 9:40 AM. Forty (40) minutes late. -On [redacted] mg was administered at 9:51 AM. Fifty-one (51) minutes late. -On [redacted] mg was administered at 10:38 AM. One (1) hour and thirty-eight (38) minutes late. -On [redacted] mcg was administered at 10:34 AM. Thirty-four (34) minutes late. -On [redacted] gm was administered at 10:34 AM. Thirty-four (34) minutes late. -On [redacted] mg was administered at 10:34 AM. Thirty-four (34) minutes late. -On [redacted] mg-unit was administered at 10:34 AM. Thirty-four (34) minutes late. -On [redacted] mg was administered at 10:34 AM. One (1) hour and thirty-four (34) minutes late.	F 684		

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 _____	04/20/2023

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 684	Continued From page 48	F 684		

-On [redacted] was administered at 10:34 AM. Thirty-four (34) minutes late.

-On [redacted].5 mg was administered at 9:49 AM. Forty-nine (49) minutes late.

-On [redacted] mg was administered ay 9:40 AM. Forty (40) minutes late.

-On [redacted] mg was administered a 10:06 AM. One (1) hour and six (6) minutes late.

-On [redacted] mg was administered at 10:01 AM. One (1) hour and one minute late.

-On [redacted] mg was administered at 12:29 PM. Three (3) hours and twenty-nine (29) minutes late.

-On [redacted] mg was administered at 12:28 PM. Three (3) hours and twenty-eight (28) minutes late.

-On [redacted] was administered at 12:29 PM. Two (2) hours and twenty-nine (29) minutes late.

-On [redacted] mcg was administered at 12:29 PM. Two (2) hours and twenty-nine (29) minutes late.

-On [redacted] gm was administered at 12:29 PM. Two (2) hours and twenty-nine (29) minutes late.

-On [redacted] tablet [redacted] mg-unit was administered at

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 _____	04/20/2023

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 684	Continued From page 49 12:29 PM. Two (2) hours and twenty-nine (29) minutes late. -On [redacted] was administered at 12:29 PM. Two (2) hours and twenty-nine (29) minutes late. -On 03/12/23, [redacted] gm scoop was administered at 10:31 AM. Thirty-one (31) minutes late. -On [redacted] was administered at 10:31 AM. Thirty-one (31) minutes late. -On [redacted] mg was administered at 10:40 AM. One (1) hour and forty (40) minutes late. -On [redacted] mg was administered at 10:40 AM. One (1) hour and forty (40) minutes late. -On [redacted] mg was administered at 10:41 AM. Forty-one (41) minutes late. -On [redacted] tablet [redacted] mg-unit was administered at 10:41 AM. Forty-one (41) minutes late. -On [redacted] was administered at 10:40 AM. Forty (40) minutes late. -On [redacted] gm scoop was administered at 10:40 AM. Forty (40) minutes late. -On [redacted] mcg was	F 684		

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 _____	04/20/2023

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 684	Continued From page 50 administered at 10:41 AM. Forty-one (41) minutes late. -On [redacted] mg was administered at 9:43 AM. Forty-three (43) minutes late. -On [redacted] mg was administered at 9:46 AM. Forty-six (46) minutes late. -On [redacted] mg was administered at 11:25 AM. Two (2) hours and twenty-five (25) minutes late. -On [redacted] mg was administered 11:24 AM. Two (2) hours and twenty-four (24) minutes late. -On [redacted] mcg was administered at 11:25 AM. One (1) hour and twenty-five (25) minutes late. -On [redacted] gm scoop was administered at 11:25 AM. One (1) hour and twenty-five (25) minutes late. -On [redacted] was administered at 11:25 AM. One (1) hour and twenty-five (25) minutes late. -On [redacted] mg was administered at 11:25 AM. One (1) hour and twenty-five (25) minutes late. -On [redacted] tablet [redacted] mg-unit was administered at 11:25 AM. One (1) hour and twenty-five (25) minutes late. -On [redacted] mg was administered	F 684		

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 _____	04/20/2023

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 684	Continued From page 51 at 10:09 AM. One (1) hour and nine (9) minutes late. -On [redacted] mg was administered at 9:47 AM. Forty-seven (47) minutes late. -On [redacted] mg was administered at 9:46 AM. Forty-six (46) minutes late. -On [redacted] mg was administered at 10:46 AM. One (1) hour and forty-six (46) minutes late. -On [redacted] mg was administered at 10:53 AM. One (1) hour and fifty-three (53) minutes late. -On [redacted] mcg was administered at 10:46 AM. Forty-six (46) minutes late. -On [redacted] tablet [redacted] mg-unit was administered at 10:46 AM. Forty-six (46) minutes late. -On [redacted] mg was administered at 10:46 AM. Forty-six (46) minutes late. -On [redacted] was administered at 10:54 AM. Fifty-four (54) minutes late. -On [redacted] mg was administered at 9:57 AM. Fifty-seven (57) minutes late. -On [redacted] mg was administered at 10:04 AM. One (1) hour and four (4) minutes late.	F 684		

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 _____	04/20/2023

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 684	Continued From page 52 -On [redacted] mg was administered at 9:36 AM. Thirty-six (36) minutes late. -On [redacted] mg was administered at 9:36 AM. Thirty-six (36) minutes late. -On [redacted] was administered at 10:31 AM. Thirty-one (31) minutes late. -On [redacted] mg was administered at 9:37 AM. Thirty-seven (37) minutes late. -On [redacted] mg was administered at 9:40 AM. Forty (40) minutes late. -On [redacted] mg was administered at 10:51 AM. One (1) hour and fifty-one (51) minutes late. -On [redacted] mg was administered at 10:51 AM. One (1) hour and fifty-one (51) minutes late. -On [redacted] tablet [redacted] mg-unit was administered at 10:51 AM. Fifty-one (51) minutes late. -On [redacted] mg was administered at 10:51 AM. Fifty-one (51) minutes late. -On [redacted] was administered at 10:52 AM. Fifty-two (52) minutes late. -On [redacted] mcg was administered at 10:53 AM. Fifty-three (53) minutes late.	F 684		

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 _____	04/20/2023

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 684	Continued From page 53	F 684		

-On [redacted] gm [redacted] was administered at 10:51 AM. Fifty-one (51) minutes late.

-On [redacted] capsule was administered at 10:52 AM. Fifty-two (52) minutes late.

-On [redacted] mg was administered at 10:51 AM. Fifty-one (51) minutes late.

-On [redacted] mg was administered at 9:58 AM. Fifty-eight (58) minutes late.

-On [redacted] mg was administered at 10:00 AM. One (1) hour late.

-On [redacted] mg was administered at 10:48 AM. One (1) hour and forty-eight (48) minutes late.

-On [redacted] mg was administered at 11:04 AM. Two (2) hours and four (4) minutes late.

-On [redacted] tablet [redacted] mg-unit was administered at 10:54 AM. Fifty-four (54) minutes late.

-On [redacted] mg was administered at 10:48 AM. Forty-eight (48) minutes late.

-On [redacted] was administered at 11:07 AM. One (1) hour and seven (7) minutes late.

-On [redacted] gm [redacted] was administered at 11:07 AM. One (1) hour and seven (7) minutes late.

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 _____	04/20/2023

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 684	Continued From page 54	F 684		

-On [redacted] mcg was administered at 11:07 AM. One (1) hour and seven (7) minutes late.

-On [redacted] capsule was administered at 11:07 AM. One (1) hour and seven (7) minutes late.

-On [redacted] gm was administered at 11:07 AM. One (1) hour and seven (7) minutes late.

-On [redacted] mg was administered at 10:14 AM. One (1) hour and fourteen (14) minutes late.

-On [redacted] mg was administered at 10:13 AM. One (1) hour and thirteen (13) minutes late.

-On [redacted] was administered at 10:01 AM. One (1) hour and one minute late.

-On [redacted] mg was administered at 10:01 AM. One (1) hour and one minute late.

-On [redacted] tablet [redacted] mg-unit was administered at 11:05 AM. One (1) hour and five (5) minutes late.

-On [redacted] mg was administered at 11:04 AM. One (1) hour and four (4) minutes late.

-On [redacted] was administered at 11:04 AM. One (1) hour and four (4) minutes late.

-On [redacted] was administered at 11:05 AM. One (1) hour and five

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 _____	04/20/2023

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 684	Continued From page 55	F 684		

(5) minutes late.

-On [redacted] gm was administered at 11:05 AM. One (1) hour and five (5) minutes late.

-On [redacted] capsule was administered at 11:04 AM. One (1) hour and four (4) minutes late.

-On [redacted] gm was administered at 11:04 AM. One (1) hour and four (4) minutes late.

-On [redacted] mg was administered at 6:01 PM. Three (3) hours and one (1) minute late.

A review of the [redacted] MAAR revealed the following:

-On [redacted] mg was administered at 9:45 AM. Forty-five (45) minutes late.

-On [redacted] mg was administered at 9:40 AM. Forty (40) minutes late.

-On [redacted] mg was administered at 10:07 AM. One (1) hour and seven (7) minutes late.

-On [redacted] mg was administered at 12:33 PM. Three (3) hours and thirty-three (33) minutes late.

-On [redacted] was administered at 10:55 AM. Fifty-five (55) minutes late.

-On [redacted] was

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 _____	04/20/2023

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 684	Continued From page 56 administered at 14:09 (2:09 PM). Four (4) hours and nine (9) minutes late. -On [redacted] mg was administered at 10:08 AM. One (1) hour and eight (8) minutes late. -On [redacted] mg was administered at 10:07 AM. One (1) hour and seven (7) minutes late. -On [redacted] mg was administered at 12:42 PM. Three (3) hours and forty-two (42) minutes late. -On [redacted] mg was administered at 12:41 PM. Three (3) hours and forty-one (41) minutes late. -On [redacted] was administered at 12:43 PM. Two (2) hours and forty-three (43) minutes late. -On [redacted] tablet [redacted] mg-unit was administered at 12:44 PM. Two (2) hours and forty-four (44) minutes late. -On [redacted] gm [redacted] was administered at 12:43 PM. Two (2) hours and forty-three (43) minutes late. -On [redacted] mcg was administered at 12:44 PM. Two (2) hours and forty-four (44) minutes late. -On [redacted] capsule was administered at 12:43. Two (2) hours and forty-three (43) minutes late.	F 684		

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 _____	04/20/2023

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 684	Continued From page 57	F 684		

-On [redacted] gm was administered at 12:43 PM. Two (2) hours and forty-three (43) minutes late.

A review of the resident's Care Plan (CP) dated [redacted] reflected a focus area that the resident plan of care would be resident centered. The goal of the CP was for Resident #35's individualized goals to be honored through the review period. Interventions included to ensure adequate resources that honor the resident's likes, dislikes, and personal preferences remain available and appropriate.

A further review of the resident's CP updated [redacted] indicated a focus area that the resident had a [redacted] related to need for supplements. The goal of the resident's CP was the resident would tolerate diet supplements as ordered. The interventions for the resident's CP included to provide and serve supplements as needed.

An additional review of the resident's Care Plan dated [redacted] reflected a focus area that the resident had [redacted] related to [redacted], repeated falls, and a sacral fracture. The goal of the resident's Care Plan was the resident would not have an interruption in normal activities due to pain through the review date. Interventions in the resident's Care Plan included to anticipate the resident's need for [redacted] and respond immediately to any [redacted]. The resident's Care Plan did not speak to administering [redacted] medication as ordered by the physician for the treatment of [redacted]

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 _____	04/20/2023

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 684	Continued From page 58 A review of the facility's policy, "Medication - Administration Policy and Procedure," revised 08/01/17, indicated that medications could be administered one hour before and one hour after the scheduled medication time. NJAC 8:39-27.1(a)	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to: a.) store respiratory equipment in a manner to prevent infection, b.) create a Care Plan for the use of [redacted] equipment for the resident and c.) provide physician orders for the care of the [redacted] equipment. This deficient practice was identified for one (1) of one (1) resident, (Resident #57) reviewed for [redacted] care and was evidenced by the following: On 04/06/23 at 11:12 AM, the surveyor observed Resident #57 in bed in his/her room. At that time, the surveyor observed that the resident had a [redacted] machine (a [redacted]	F 695	F 695 Respiratory/Tracheostomy Care and Suctioning (C-Pap/Bi Pap) What corrective action will be accomplished for those residents affected by the deficient practice? Resident #57 was identified as being affected by the deficient practice. The Resident's [redacted] equipment was serviced on April 10th, 2023, with new attachments [redacted]) replacing the existing one. Equipment was also cleaned and bagged to prevent infection. The physicians order and plan of care were updated to reflect use and care of [redacted] equipment.	5/22/23

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 _____	04/20/2023

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 695	Continued From page 59 [redacted] and a [redacted] on the nightstand next to the resident's bed. The surveyor saw that the [redacted] was left open to air, uncovered and was in direct contact with the [redacted] machine. The surveyor observed that the resident had a [redacted], resting on the [redacted] machine (a small machine that [redacted]. The [redacted] was observed in direct contact with the [redacted] machine. The [redacted] the [redacted] mask was undated. The resident told the surveyor that the nurse took care of the [redacted] and [redacted] when he/she was done using them. On 04/11/23 at 11:28 AM, the surveyor observed the resident in bed. The surveyor further observed the [redacted] machine on the nightstand with the undated [redacted] not stored in a plastic bag, and in direct contact with the [redacted] machine. The surveyor further observed that the [redacted] and [redacted] were undated and in direct contact with the [redacted] machine. The tubing connected to the [redacted] was in direct contact with the floor in the resident's room. At the time of the observation, the resident told the surveyor that the nurse put the [redacted] on him/her and took them off. On 04/14/23 at 11:55 AM, the surveyor entered Resident #57's room. The surveyor observed the [redacted] in direct contact with the CD player on the resident's nightstand. The surveyor further observed that the [redacted] was made from a clear, soft plastic. The [redacted] to it. The resident's [redacted] was observed to be in direct contact with the straps of the [redacted]	F 695	How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the same deficient practice. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur? The Nurse Educator began re-education to the nursing staffing on April 7th, 2023, ensuring [redacted] equipment is stored in a manner to prevent infection, a care plan is created for the use of [redacted] equipment and to obtain a physician order for the care of [redacted] equipment. The Director of Nursing and/or designee will conduct random audits for the following: ensuring [redacted] equipment is stored in a manner to prevent infection, a care plan is created for the use of [redacted] equipment and to obtain a physician order for the care of [redacted] equipment for 5 days a week for 4 weeks, 3 days a week for four weeks and then weekly x4 weeks. How will the corrective action be monitored to ensure the deficient practice will not recure? The DON and/ or designee will report the results of the audit to the Quality Assurance Performance Improvement Committee (QAPI) meeting scheduled for May 25th, 2023, and then monthly x3	

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 _____	04/20/2023

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 695	Continued From page 60 and resting on the [redacted] machine. None of the [redacted] was dated for the use of the [redacted] y equipment. The resident was not in the room at the time of the surveyor's observations. On 04/14/23 at 11:48 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that the resident was alert, but forgetful at times. The CNA told the surveyor that the resident had [redacted] treatments next to his/her bedside, but she had never seen the resident wear [redacted] The CNA stated that it was the resident's nurse's responsibility to take care of the resident's medications, [redacted] equipment, and [redacted] machine. The CNA further stated that to her knowledge the resident did not touch the [redacted] equipment because, "the resident was not the type to touch stuff and would wait." On 04/14/23 at 12:00 PM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that she was somewhat familiar with the resident and that the resident was [redacted], and able to make needs known. The LPN further stated that the resident wore a [redacted] at [redacted] and required [redacted] treatments. On 04/14/23 at 12:02 PM, the surveyor entered the resident's vacant room with the resident's LPN who observed the [redacted] and [redacted] in the presence of the surveyor. The LPN stated that the inside of the [redacted] and [redacted] appeared like they needed to be cleaned and were supposed to be rinsed after each use. The LPN further stated that the [redacted] was worn at [redacted] and should have been placed in a plastic bag when not in use, as well as the [redacted] for the resident. The LPN told the	F 695	months. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director, and Department Heads.	

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 _____	04/20/2023

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 695	Continued From page 61 surveyor that the [redacted] for the [redacted]r needed to be changed out weekly and dated. The LPN further explained to the surveyor that if a resident required a [redacted] and [redacted] treatments, that it should be something that was reflected in the resident's Care Plan (CP-an individualized plan used to direct a resident's care.) The LPN told the surveyor that the Licensed Practical Nurse/Acting Unit Manager (LPN/AUM) was responsible for creating the CPs for the resident. On 04/14/23 at 12:10 PM, the surveyor interviewed the LPN/AUM who stated that the resident was [redacted] and oriented to [redacted], and [redacted], and was [redacted]. The LPN/AUM told the surveyor that the resident had a diagnosis of [redacted], wore a [redacted] at [redacted] as ordered by the physician and received [redacted] treatments. The LPN/AUM further stated that the [redacted] and [redacted] were required to be changed weekly, labeled, dated, and that when not in use, stored in a plastic bag. The LPN/AUM explained that after the resident used the [redacted], they should have been wiped down after every use for infection control purposes. The LPN/AUM stated that if the resident required a [redacted] and [redacted] machine for care, that they should have been care planned for. On 04/14/23 at 12:16 PM, the surveyor reviewed the resident's CP in the presence of the LPN/AUM who identified in the presence of the surveyor that the resident did not have a CP for the use of the [redacted] machine and [redacted]r treatments. On 04/14/23 at 1:14 PM, the surveyor interviewed	F 695		

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 _____	04/20/2023

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 695	Continued From page 62	F 695		

the facility's Infection Preventionist who stated that regarding care of [redacted] equipment, she would expect that the [redacted] would be dated, the equipment was cleaned after use, and placed in a plastic bag after each use to prevent the spread of an infection.

The surveyor reviewed the medical record for Resident #57.

A review of the resident's Admission Record (an Admission Summary) reflected that the resident was admitted to the facility in [redacted] and had diagnoses which included but were not limited to [redacted] and [redacted]

A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident had [redacted]. A further review of the resident's MDS, Section [redacted], [redacted] indicated the resident was on [redacted] therapy.

A review of the resident's [redacted] Order Summary Report (OSR) reflected a Physician's Order (PO), dated [redacted], to apply [redacted] at bedtime and remove in AM every day and evening shift for preventive [redacted]. A further review of the [redacted] OSR did not reflect a PO for the care of the [redacted] machine, [redacted],

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 _____	04/20/2023

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 695	Continued From page 63 [redacted], and [redacted]. A review of the resident's [redacted] Medication Administration Record (MAR) did not reflect a PO for the care of the [redacted] machine, [redacted], [redacted], and [redacted]. A review of the resident's [redacted] Treatment Administration Record (TAR) reflected that the nurses were signing from [redacted] through [redacted] for the application of the [redacted] at bedtime and removal of the [redacted] in the AM, every day and evening shift for preventative [redacted]. A further review of the [redacted] TAR did not reveal a PO for the care [redacted] machine, [redacted], [redacted], and [redacted]. A review of the resident's CP dated [redacted] did not reveal a focus area that the resident had a diagnoses of [redacted] and [redacted] A further review of the resident's CP did not indicate that the resident required [redacted] equipment such as a [redacted] and [redacted] treatments. The CP did not reflect the care of the resident's [redacted] equipment. A review of the facility's policy, '[redacted] Administration Policy and Procedure," revised 08/01/17, indicated that all [redacted], [redacted], and [redacted] used to deliver [redacted] would be changed weekly and when visibly soiled. The facility's [redacted] Administration Policy and Procedure further indicated, [redacted] items will be stored in a plastic bag at the resident's bedside to protect the equipment from dust and dirt when not in use." NJAC 8:39-27.1(a)	F 695		

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 _____	04/20/2023

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 697 SS=H	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation it was determined that the facility failed to administer a physician ordered scheduled pain medication to a resident who was verbalizing [redacted] at a level of ten (10) out of ten. This deficient practice was identified for one (1) of one residents, (Resident #35) reviewed for [redacted] management and was evidenced by the following: Refer to F684E On 04/06/23 at 12:35 PM, Surveyor #1 observed Surveyor #2 talking to Resident #35 at the end of the hallway on the [redacted] unit. Surveyor #1 overheard the resident tell Surveyor #2 that he/she had not received any of his/her medications that day and their [redacted] were in [redacted]. At that time, Surveyor #1 observed Surveyor #2 walk toward the Licensed Practical Nurse/Acting Unit Managers (LPN/AUM) office to notify the facility staff member that Resident #35 was requesting his/her medications. On 04/06/23 at 12:36 PM, Surveyor #1 walked down the end of the hallway toward Resident #35 and observed the resident seated in his/her wheelchair. The resident stopped the surveyor and stated that he/she had not received their	F 697	F 697 PAIN MANAGEMENT What corrective action will be accomplished for those residents affected by the deficient practice? Resident #35 was immediately given her scheduled pain medication. The Director of Nursing provided 1:1 education to the administering nurse on April 6, 2023, regarding timely medication administration per physician's order. The Pharmacy Consultant conducted a medication pass observation to the administering nurse on April 10, 2023, with satisfactory performance. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by untimely administration of medications. What measures will be put into place or what systemic changes will be made to	5/22/23

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 _____	04/20/2023

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 697	Continued From page 65 medications that day and was in [redacted]. The resident stated his/her [redacted] was constant and in his/her [redacted]. The resident further stated, "I don't know why they haven't given me my medications." On 04/06/23 at 12:40 PM, Surveyor #1 interviewed the LPN/AUM at the medication cart in front of the nurse's station. The surveyor asked the LPN/AUM if Resident #35 had received his/her pain medications. The LPN/AUM stated that she had just taken the resident's [redacted] because the resident was on a [redacted] medication, and she was going to administer the resident's medications now. On 04/06/23 from 12:40 PM to 12:46 PM, Surveyor #1 stood at the nurse's station, next to the medication cart and observed the LPN/AUM gather the resident's medications, walk down the hallway, and administer medications to Resident #35. On 04/06/23 at 12:48 PM, the surveyor reviewed Resident #35's April 2023 Medication Administration Record (MAR) on the computer attached to the medication cart in the presence of the LPN/AUM. At that time, Surveyor #1 identified that the resident had not received his/her routine scheduled [redacted] milligrams (mg) by mouth three times a day at 8:00 AM and had not received the application of his/her [redacted] to the [redacted] which was scheduled to be administered at 9:00 AM. Surveyor #1 asked the LPN/AUM what medications she had administered to the resident and the LPN/AUM stated that she had just administered all the resident's 8:00 AM and 9:00 AM physician prescribed medications and "normally would not	F 697	ensure the deficient practice will not recur? The Director of Nursing and or designee began re-education on April 6th, 2023, to the nursing staff regarding the importance of timely administration of physician ordered medications / treatments and assessment of resident for both [redacted] and n[redacted] cues for [redacted] To reduce nursing time spent on medication and treatment pass, The Director of Nursing and Medical Director reviewed the medication process to address polypharmacy and discontinuation of medication parameters for stable residents. The Director of Nursing and Medical Director will continue to meet weekly to review and make any appropriate change to a patient's medication regime. Pharmacy Consultant is scheduled on May 15th, 2023, to begin conducting medication pass on the nursing staff. The results of the medication pass will be provided to the Director of Nursing. The Unit Managers and or designee will conduct medication pass observing the timely administration of scheduled physician ordered medications / treatments 5 times a week x4 weeks, then 3x a week for four weeks and then weekly for 4 weeks. The results of this audit will be reviewed during clinical morning meeting.	

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 _____	04/20/2023

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 697	Continued From page 66 have administered them this late." Surveyor #1 asked the LPN/AUM why the medications were administered outside of the physician prescribed time frame, and the LPN/AUM stated that she was caring for other residents, it was an oversite, and there were other nurses available that could have helped her. The surveyor asked the LPN/AUM if she had evaluated Resident #35's [redacted] prior to administering the [redacted] medication, [redacted] The LPN/AUM stated that she had not evaluated the resident's [redacted] prior to the administration of the [redacted] because it was a routine schedule [redacted] medication, and the resident had a diagnosis of [redacted]. The LPN/AUM further stated that if a resident had [redacted], the [redacted] medication should have been administered according to Physician Orders (PO)'s to prevent the resident from being in [redacted]. The LPN/AUM told Surveyor #1 that she had one hour before and one hour after to administer the resident his/her medications. The LPN/AUM explained that when she had administered the resident his/her medications the resident had complained of [redacted] because the resident did not sleep with his/her usual [redacted] the [redacted] before. On 04/06/23 at 01:01 PM, Surveyor #1 interviewed Resident #35 in his/her room. The surveyor asked the resident what his/her [redacted] was on a scale of [redacted]. The resident stated his/her [redacted] was a [redacted] because he/she had, [redacted]. At that time, the resident showed the surveyor that he/she was unable to [redacted] his/her [redacted] and was only able to slowly [redacted] them from the [redacted] without [redacted] The resident stated, " [redacted] is. I'll be so truthful to you. Sometimes the [redacted] [redacted] I've had [redacted] for [redacted] years, and	F 697	How will the corrective action be monitored to ensure the deficient practice will not recure? The Director of Nursing and/ or designee will report results of the audit to the Quality Assurance Performance Improvement Committee (QAPI) meeting scheduled for May 25th, 2023, and then monthly x3 months. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director, and Department Heads.	

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 _____	04/20/2023

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 697	Continued From page 67 the [redacted]. [redacted] The resident further told the surveyor that he/she, "didn't want to cause problems for nobody and just wanted to be treated right." On 04/06/23 at 01:26 PM, Surveyor #1 interviewed the resident's Certified Nursing Aide (CNA) who stated that he had been working at the facility for a [redacted] and Resident #35 was on his care assignment that day. The CNA stated that he had provided care to the resident about four (4) to five (5) times before. Surveyor #1 asked the CNA if the resident ever [redacted] about [redacted] The CNA stated that, yes, the first time anyone provided care to the resident, he/she would tell the staff that took care of him/her that he/she had [redacted] in his/her [redacted] and to be careful with the [redacted]. The CNA told Surveyor #1 that he had helped the resident get dressed earlier in the day around 9:45 AM - 10:00 AM and at that time the resident did not [redacted], but the resident told him to be mindful of his/her [redacted] The CNA further stated that when he had dressed the resident that morning, he dressed the resident very slowly, helped the resident get out of bed, and sat the resident in his/her wheelchair. The CNA told the surveyor that the resident did not tell him that he/she had not been administered his/her medications when he provided care to the resident that morning. On 04/06/23 at 01:46 PM, in the presence of the Licensed Nursing Home Administrator (LNHA), Surveyor #1 interviewed the Director of Nursing (DON) who stated that the resident's medications should have been administered as ordered by the physician, one hour before and one hour after the	F 697		

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 _____	04/20/2023

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 697	Continued From page 68	F 697		

scheduled medication time, unless otherwise indicated in the PO. The DON stated that he was a little familiar with the residents and the resident had a past medical history of [redacted] Surveyor #1 asked the DON, what was the importance of administering [redacted] medication as ordered by the physician for a resident with [redacted] The DON stated that it was important that [redacted] medications were administered as ordered by the physician to alleviate or minimize the [redacted] as much as possible.

On 04/11/23 at 11:29 AM, Surveyor #1 interviewed the facility's Consultant Pharmacist (CP) who stated that medication was to be administered one hour before and one hour after the scheduled medication times. The CP further stated that if a resident was prescribed routine medications to treat [redacted], the expectation would have been for the nurses to administer the medications as scheduled to hopefully keep the resident from having [redacted]

On 04/11/23 at 12:56 PM, Surveyor #1 conducted a follow up interview with the resident in his/her room who stated that his/her [redacted] had been better, and he/she was now receiving his/her medications on time.

On 04/12/23 at 11:09 AM, Surveyor #1 conducted a follow up interview with the DON who stated that he had reviewed Resident #35's [redacted] and [redacted] Medication Administration Audit Report (MAAR) and had identified that the nurses had not been administering Resident #35's medications on time as prescribed by the physician.

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 _____	04/20/2023

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 697	Continued From page 69 On 04/18/23 at 09:47 AM, Surveyor #1 interviewed the resident's Primary Care Physician (PCP) who stated that when a resident had a PO for a medication, the medication should be administered one hour before and one hour after the scheduled administration time. Surveyor #1 asked the PCP why administering scheduled [redacted] medication was important if a resident had diagnoses that supported [redacted]. The PCP stated that it was important to administer the [redacted] medication on time and appropriately to manage the resident's [redacted] and keep the resident's [redacted] at a [redacted] that was [redacted] The surveyor reviewed the electronic medical record for Resident #35. A review of the resident's Admission Record (an Admission Summary) reflected that the resident was a long term care resident at the facility and had diagnoses which included but were not limited to [redacted] A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted]	F 697		

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 _____	04/20/2023

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 697	Continued From page 70	F 697		

indicated the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident's cognition was [redacted] A further review of the resident's MDS, [redacted] Assessment Interview indicated that the resident's [redacted] was almost [redacted] made it hard for the resident to [redacted], and the resident verbally described their [redacted].

A review of the resident's [redacted] Order Summary Report (OSR) reflected a PO dated [redacted] for the medication, [redacted] mg by mouth [redacted] times a day for [redacted], please give at 8:00 AM, 2:00 PM, and 8:00 PM. A further review of the resident's [redacted] OSR revealed a PO dated [redacted] for [redacted] apply to [redacted] one time a day for [redacted]. Remove [redacted] at [redacted] and apply per schedule.

A review of the resident's [redacted] MAR revealed that the nurses had signed that the medication [redacted] mg by mouth [redacted] times a day for [redacted] was administered at 0800 (8:00 AM), 1400 (2:00 PM), and 2000 (8:00 PM) throughout the month of [redacted] A further review of the [redacted] MAR revealed that the nurses had signed that the [redacted] was applied topically to the resident's [redacted] one time a day for [redacted] at 0900 (9:00 AM) and removed at 2100 (9:00 PM) throughout the month of [redacted]

A review of the resident's [redacted] OSR reflected a PO [redacted] for the medication, [redacted] mg by mouth [redacted] times a day for [redacted], please give at 8:00 AM, 2:00 PM, and 8:00 PM. A further review of the resident's

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 _____	04/20/2023

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 697	Continued From page 71 [redacted] OSR revealed a PO dated [redacted] for [redacted] apply to [redacted] one time a day for [redacted]. Remove the [redacted] and remove per schedule. A review of the resident's [redacted] MAR revealed that the nurses were signing that the medication [redacted] mg by mouth was administered [redacted] times a day for [redacted] at 0800 (8:00 AM), 1400 (2:00 PM), and 2000 (8:00 PM) from [redacted] through [redacted] A further review of the [redacted] MAR revealed that the nurses had signed that they had applied the [redacted] topically to the resident's [redacted] r one time a day for [redacted] at 0900 (9:00 AM) and removed at 2100 (9:00 PM) from [redacted] through [redacted] at 0900. A review of the [redacted] MAAR revealed the following: -On [redacted] mg was administered at 9:48 AM. Forty-eight (48) minutes late. -On [redacted] mg was administered at 10:31 AM. One (1) hour and thirty-one (31) minutes late. -On [redacted] was administered at 10:31 AM. Thirty-one (31) minutes late. -On [redacted] mg was administered at 10:36 AM. One (1) hour and thirty-six (36) minutes late. -On [redacted] was administered at 10:38 AM. Thirty-eight (38) minutes late.	F 697		

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 _____	04/20/2023

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 697	Continued From page 72 -On [redacted] mg was administered at 9:51 AM. Fifty-one (51) minutes late. -On [redacted] mg was administered at 10:34 AM. One (1) hour and thirty-four (34) minutes late. -On [redacted] was administered at 10:34 AM. Thirty-four (34) minutes late. -On [redacted] mg was administered ay 9:40 AM. Forty (40) minutes late. -On [redacted] mg was administered a 10:06 AM. One (1) hour and six (6) minutes late. -On [redacted] mg was administered at 12:29 PM. Three (3) hours and twenty-nine (29) minutes late. -On [redacted] was administered at 12:29 PM. Two (2) hours and twenty-nine (29) minutes late. -On [redacted] was administered at 10:31 AM. Thirty-one (31) minutes late. -On [redacted] mg was administered at 10:40 AM. One (1) hour and forty (40) minutes late. -On [redacted] was administered at 10:40 AM. Forty (40) minutes late.	F 697		

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 _____	04/20/2023

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 697	Continued From page 73 -On [redacted] mg was administered at 9:46 AM. Forty-six (46) minutes late. -On [redacted] mg was administered at 11:25 AM. Two (2) hours and twenty-five (25) minutes late. -On [redacted] was administered at 11:25 AM. One (1) hour and twenty-five (25) minutes late. -On [redacted] mg was administered at 10:09 AM. One (1) hour and nine (9) minutes late. -On [redacted] mg was administered at 9:47 AM. Forty-seven (47) minutes late. -On [redacted] mg was administered at 10:46 AM. One (1) hour and forty-six (46) minutes late. -On [redacted] was administered at 10:54 AM. Fifty-four (54) minutes late. -On [redacted] mg was administered at 9:57 AM. Fifty-seven (57) minutes late. -On [redacted] mg was administered at 9:36 AM. Thirty-six (36) minutes late. -On [redacted] was administered at 10:31 AM. Thirty-one (31) minutes late. -On [redacted] mg was administered at 9:40 AM. Forty (40) minutes late.	F 697		

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 _____	04/20/2023

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 697	Continued From page 74 -On [redacted] mg was administered at 10:51 AM. One (1) hour and fifty-one (51) minutes late. -On [redacted] was administered at 10:52 AM. Fifty-two (52) minutes late. -On [redacted] mg was administered at 9:58 AM. Fifty-eight (58) minutes late. -On [redacted] mg was administered at 10:48 AM. One (1) hour and forty-eight (48) minutes late. -On [redacted] was administered at 11:07 AM. One (1) hour and seven (7) minutes late. -On [redacted] mg was administered at 10:14 AM. One (1) hour and fourteen (14) minutes late. -On [redacted] was administered at 10:01 AM. One (1) hour and one minute late. -On [redacted] was administered at 11:05 AM. One (1) hour and five (5) minutes late. -On [redacted] mg was administered at 6:01 PM. Three (3) hours and one (1) minute late. A review of the [redacted] MAAR revealed the following: -On [redacted] mg was administered at 9:45 AM. Forty-five (45) minutes late.	F 697		

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 _____	04/20/2023

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 697	Continued From page 75	F 697		

[redacted] mg was administered at 12:33 PM. Three (3) hours and thirty-three (33) minutes late.

-[redacted] was administered at 10:55 AM. Fifty-five (55) minutes late.

-On [redacted] was administered at 14:09 (2:09 PM). Four (4) hours and nine (9) minutes late.

-On [redacted] mg was administered at 10:07 AM. One (1) hour and seven (7) minutes late.

-On [redacted] mg was administered at 12:41 PM. Three (3) hours and forty-one (41) minutes late.

-On [redacted] was administered at 12:43 PM. Two (2) hours and forty-three (43) minutes late.

A review of the resident's physician progress note dated [redacted] at 2100 (9:00 PM) indicated that the resident had a past medical history of [redacted] and was on the medication [redacted] times a day as a [redacted] management regimen.

A review of the resident's Care Plan (CP) dated [redacted] reflected a focus area that the resident had [redacted] related to [redacted], repeated [redacted]. The goal of the resident's CP was that the resident would not have an interruption in normal activities due to [redacted] through the review date. Interventions in the

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 _____	04/20/2023

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 697	Continued From page 76 resident's CP included to anticipate the resident's need for [redacted] and respond immediately to any [redacted]. The resident's CP did not speak to administering [redacted] medication as ordered by the physician for the treatment of [redacted]. A review of the facility's undated policy, [redacted] Assessment and Documentation Policy and Procedure," indicated, "It is the policy of [the facility] to provide an effective and appropriate method of assessment and documentation of our resident's [redacted] of [redacted] and attempt to identify the source and effectively manage resident's [redacted] The effective treatment, reduction or elimination of [redacted] and the associated [redacted] will enable the resident/patient to participate or increase participation in therapy or activities of daily living." A review of the facility's policy, "Medication - Administration Policy and Procedure," revised 08/01/17, indicated that medications could be administered one hour before and one hour after the scheduled medication time.	F 697		
F 711 SS=E	NJAC 8:39-27.1(a) Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;	F 711		5/22/23

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 _____	04/20/2023

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 711	Continued From page 77 §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review and review of other pertinent facility documentation it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents documented physician visit progress notes at the time of each visit. This deficient practice was identified for seven (7) of sixteen (16) residents reviewed (Resident #6, #13, #29, #31, #57, #72, #225) and one (1) of two (2) physicians reviewed for physician visits and was evidenced by the following: On 04/18/23 at 12:23 PM, the surveyor reviewed physician visits in the electronic medical records for the following residents which revealed the following information: 1.) The Admission Record (AR) indicated that Resident #6 was admitted to the facility with the diagnoses which include but was not limited to [redacted] The surveyor reviewed the Physician Visit Progress Note (PVPN) which revealed four (4) visits were documented late. The PVPN reflected the following:	F 711	F711 PHYSICIAN VISIT What corrective action will be accomplished for those residents affected by the deficient practice? Residents #6, #13, #29, #31, #57, #72 and #225 were identified as being affected by the deficient practice. Resident #29 was discharged from the facility. The Director of Nursing provided 1:1 education on April 27, 2023, to the identified physician regarding completing of physician visit progress notes at the time of each visit. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by this deficient practice. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur? The Administrator, Director of Nursing and	

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 _____	04/20/2023

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 711	Continued From page 78 -On [redacted] there was a PVPN which reflected that the progress note was created on [redacted], which indicated it was five (5) days late. -On [redacted] there was a PVPN however, the progress note was created on [redacted] which indicated it was seven (7) days late. -On [redacted], there was a PVPN however, the progress note was created on [redacted], which indicated it was one (1) day late. -On [redacted] there was a PVPN however, the progress note was created on [redacted] which indicated it was five (5) days late. 2.) The AR indicated that Resident #13 was admitted to the facility with the diagnoses which included but was not limited to [redacted] The surveyor reviewed the PVPN and there were fifteen (15) visits that were documented as being late. The PVPN reflected the following: -On [redacted], there was a PVPN however, the progress note was created on [redacted], which indicated it was three (3) days late. -On [redacted] there was a PVPN however, the progress note was created on [redacted], which indicated it was 16 days late. -On [redacted], there was a PVPN however, the progress note was created on [redacted], which indicated it was 12 days late. -On [redacted], there was a PVPN however, the	F 711	Medical Director began education on April 27th, 2023, to the physicians regarding timely documentation of provider visits. The Director of Nursing and or designee will audit timeliness of physician visits 5 times a week x4 weeks, then 3x a week for four weeks and then weekly for 4 based on creation date versus effective date of the physician progress note. How will the corrective action be monitored to ensure the deficient practice will not recure? The Director of Nursing and/or designee will report the physician visit audit results during the Quality Assurance Performance Improvement (QAPI) meeting scheduled for May 25th, 2023, and then monthly x3 months. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads.	

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 _____	04/20/2023

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 711	Continued From page 79 progress note was created on [redacted] which indicated it was nine (9) days late. -On [redacted], there was a PVPN however, the progress note was created on [redacted] which indicated it was 14 days late. -On [redacted], there was a PVPN however, the progress note was created on [redacted] which indicated it was five (5) days late. -On [redacted] there was a PVPN however, the progress note was created on [redacted], which indicated it was five (5) days late. -On [redacted], there was a PVPN however, the progress note was created on [redacted], which indicated it was eight (8) days late. -On [redacted], there was a PVPN however, the progress note was created on [redacted], which indicated it was four (4) days late. -On [redacted], there was a PVPN however, the progress note was created on [redacted] which indicated it was five (5) days late. -On [redacted], there was a PVPN however, the progress note was created on [redacted], which indicated it was nine (9) days late. -On [redacted], there was a PVPN however, the progress note was created on [redacted] which indicated it was seven (7) days late. -On [redacted] there was a PVPN however, the progress note was created on [redacted] which indicated it was six (6) days late.	F 711		

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 _____	04/20/2023

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 711	Continued From page 80 -On [redacted], there was a PVPN however, the progress note was created on [redacted] which indicated it was 12 days late. -On [redacted], there was a PVPN however, the progress note was created on [redacted], which indicated it was eight (8) days late. 3.) The AR indicated that Resident #29 was admitted to the facility with the diagnoses which included but was not limited to [redacted] The surveyor reviewed the PVPN and there were eight (8) visits that were documented as being late. The PVPN reflected the following: -On [redacted] there was a PVPN however, the progress note was created on [redacted], which indicated it was five (5) days late. -On [redacted] there was a PVPN however, the progress note was created on [redacted] which indicated it was five (5) days late. -On [redacted] there was a PVPN however, the progress note was created on [redacted], which indicated it was five (5) days late. -On [redacted], there was a PVPN however, the progress note was created on [redacted], which indicated it was five (5) days late. -On [redacted] there was a PVPN however, the progress note was created on [redacted], which indicated it was six (6) days late. -On [redacted] there was a PVPN however, the	F 711		

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 _____	04/20/2023

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 711	Continued From page 81	F 711		

progress note was created on [redacted], which indicated it was seven (7) days late.

-On [redacted] there was a PVPN however, the progress note was created on [redacted], which indicated it was eight (8) days late.

-On [redacted], there was a PVPN however, the progress note was created on [redacted] which indicated it was seven (7) days late.

4.) The AR indicated that Resident #31 was admitted to the facility with the diagnoses which included but was not limited to [redacted].

The surveyor reviewed the PVPN and there were seven (7) visits that were documented as being late. The PVPN reflected the following:

-On [redacted], there was a PVPN however, the progress note was created on [redacted], which indicated it was seven (7) days late.

-On [redacted] there was a PVPN however, the progress note was created on [redacted] which indicated it was five (5) days late.

-On [redacted], there was a PVPN however, the progress note was created on [redacted] which indicated it was five (5) days late.

-On [redacted] there was a PVPN however, the progress note was created on [redacted], which indicated it was five (5) days late.

-On [redacted], there was a PVPN however, the progress note was created on [redacted] which

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 _____	04/20/2023

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 711	Continued From page 82 indicated it was seven (7) days late. -On [redacted] there was a PVPN however, the progress note was created on [redacted] which indicated it was six (6) days late. -On [redacted] there was a PVPN however, the progress note was created on [redacted] which indicated it was four (4) days late. 5.) The AR indicated that Resident #57 was admitted to the facility with the diagnoses which included but was not limited to [redacted] and [redacted]. The surveyor reviewed the PVPN and there were two (2) visits that were documented as being late. The PVPN reflected the following: -On [redacted], there was a PVPN however, the progress note was created on [redacted], which indicated it was three (3) days late. -On [redacted] there was a PVPN however, the progress note was created on [redacted], which indicated it was eight (8) days late. 6.) The AR indicated that Resident #72 was admitted to the facility with the diagnoses which included but was not limited to [redacted] and [redacted] The surveyor reviewed the PVPN and there were twenty (20) visits that were documented as being late. The PVPN reflected the following: -On [redacted] there was a PVPN however, the	F 711		

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 _____	04/20/2023

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 711	Continued From page 83 progress note was created on [redacted], which indicated it was seven (7) days late. -On [redacted], there was a PVPN however, the progress note was created on [redacted], which indicated it was eight (8) days late. -On [redacted] there was a PVPN however, the progress note was created on [redacted], which indicated it was one (1) day late. -On [redacted] there was a PVPN however, the progress note was created on [redacted] which indicated it was eight (8) days late. -On [redacted] there was a PVPN however, the progress note was created on [redacted] which indicated it was 15 days late. -On [redacted] there was a PVPN however, the progress note was created on [redacted], which indicated it was 11 days late. -On [redacted], there was a PVPN however, the progress note was created on [redacted], which indicated it was five (5) days late. -On [redacted] there was a PVPN however, the progress note was created on [redacted] which indicated it was five (5) days late. -On [redacted], there was a PVPN however, the progress note was created on [redacted], which indicated it was 14 days late. - On [redacted], there was a PVPN however, the progress note was created on [redacted], which indicated it was eight (8) days late.	F 711		

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 _____	04/20/2023

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 711	Continued From page 84 - On [redacted], there was a PVPN however, the progress note was created on [redacted] which indicated it was five (5) days late. - On [redacted], there was a PVPN however, the progress note was created on [redacted] which indicated it was five (5) days late. - On [redacted], there was a PVPN however, the progress note was created on [redacted] which indicated it was nine (9) days late. -On [redacted], there was a PVPN however, the progress note was created on [redacted] which indicated it was four (4) days late. - On [redacted] there was a PVPN however, the progress note was created on [redacted], which indicated it was five (5) days late. - On [redacted], there was a PVPN however, the progress note was created on [redacted], which indicated it was four (4) days late. -On [redacted], there was a PVPN however, the progress note was created on [redacted], which indicated it was six (6) days late. - On [redacted] there was a PVPN however, the progress note was created on [redacted] which indicated it was 12 days late. - On [redacted], there was a PVPN however, the progress note was created on [redacted] which indicated it was eight (8) days late. - On [redacted], there was a PVPN however, the progress note was created on [redacted] which indicated it was seven (7) days late.	F 711		

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 _____	04/20/2023

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 711	Continued From page 85	F 711		

7.) The AR indicated that Resident #225 was admitted to the facility with the diagnoses which included but was not limited to [redacted] and [redacted]).

The surveyor reviewed the PVPN and there were six (6) visits that were documented as being late. The PVPN reflected the following:

- On [redacted], there was a PVPN however, the progress note was created on [redacted], which indicated it was five (5) days late.

- On [redacted], there was a PVPN however, the progress note was created on [redacted] which indicated it was five (5) days late.

-On [redacted] there was a PVPN however, the progress note was created on [redacted], which indicated it was five (5) days late.

-On [redacted], there was a PVPN however, the progress note was created on [redacted], which indicated it was seven (7) days late.

- On [redacted] there was a PVPN however, the progress note was created on [redacted], which indicated it was four (4) days late.

- On [redacted] there was a PVPN however, the progress note was created on [redacted] which indicated it was 12 days late.

On 04/19/23 at 11:17 AM, the surveyor conducted a telephone interview in the presence of the survey team with the primary care physician (PCP) for the above-mentioned residents. The

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 _____	04/20/2023

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 711	Continued From page 86	F 711		

PCP stated that he came to see the residents, usually between 24 - 48 hours after admission and that his notes were dictated and then sent to the scribe (a person who copied out documents). He explained what the word "dictates" meant that he would make "little notes" and send them to two (2) Registered Nurses (RN's). He stated that the nurses would then type up the notes and he proofread the note and then transferred the notes into the resident's electronic medical records (EMR). He stated that he would also make corrections if needed. He stated that he would do this on a monthly bases for the long term care (LTC) residents. The PCP stated that he was not aware that the federal regulations regarding documentation of physician visit progress notes was to be done at the time of the visit, but would be complying with the regulation moving forward. He stated that if he came in and saw a resident that needed immediate treatment that he would speak to the nurse, prescribe a treatment order, and would follow through with the treatment and care for the resident. He stated that he wanted to do what was right for the patients and voiced an understanding of the regulations.

On 04/19/23 at 11:55 AM, the surveyor conducted a telephone interview in the presence of the survey team with the Medical Director (MD). The MD stated that every new admission should have been seen by a physician within the timeframe of 72 hours. The MD stated that after the physician assessed the resident that the physician should have documented in the resident's record in a timely manner. The MD confirmed that the physicians should comply with the facility policy and state and federal regulations concering physician visits and timely documentation.

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 _____	04/20/2023

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 711	Continued From page 87 The surveyor reviewed the facility's policy, "Physician Services," revised April 2013, which revealed that the care of each resident was under the supervision of the licensed physician. The policy reflected that the physician will pertinent timely medical assessments; prescribe appropriate medical regimen; provide adequate timely information about the resident's medical condition and medical needs; visit the resident at appropriate intervals. The policy also indicated that physician progress notes would be maintained in accordance with OBRA (Omnibus Budget Reconciliation Act) regulations and facility policy. NJAC 8:39-23.2 (b)	F 711		
F 755 SS=D	- Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755		5/22/23

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 _____	04/20/2023

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 755	Continued From page 88 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documentation it was determined, that the facility failed to: a.) ensure that medication records were in order and b.) an account of all controlled medications were maintained and reconciled for one (1) resident's, (Resident #43's) controlled medications which was identified during the inspection of medication carts. This deficient practice was observed in 1 of three (3) medication carts inspected and was evidenced by the following: The Admission Record indicated that Resident #43 was admitted to the facility with diagnoses which included but was not limited to [redacted] ([redacted]).	F 755	F711 PHARMACY What corrective action will be accomplished for those residents affected by the deficient practice? Resident #43 was assessed and found to be clinically and functionally stable. There was no undesirable outcome as a result of the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? There were 3 other residents identified with liquid controlled medications that could be affected by this deficient	

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 _____	04/20/2023

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 755	Continued From page 89 The quarterly Minimum Data Set (MDS), an assessment used to facilitate the management of a resident's care) dated [redacted], indicated that the resident had [redacted]. The MDS further indicated that the resident was unable to be interviewed. The surveyor reviewed the resident's electronic medical record (EMR) for the last six months which revealed the resident did not have [redacted] On 04/18/23 at 09:36 AM, the surveyor inspected the medication cart on the [redacted]-wing [redacted] room numbers. During a reconciliation of controlled medications with the Licensed Practical Nurse (LPN #1) the surveyor observed that a controlled medication for Resident #43 named [redacted] medication used to [redacted] milligrams (mg) per milliliter (ml) was supposed to have [redacted] ml of the medication left in the bottle and the surveyor observed [redacted] ml left in the bottle. LPN #1 confirmed with the surveyor that the narcotic count was not accurate and was [redacted] ml over the amount that it should have been. On 04/18/23 10:46 AM, the surveyor interviewed LPN #1 who stated that she arrived at the facility at 7:30 AM on 04/18/23 and did not perform the controlled medication reconciliation. She stated that the reconciliation of the controlled medications was performed by two other nurses before she arrived the morning of 04/18/23. She further stated that she did not recognize the signatures that were documented on the controlled reconciliation sheet and could not identify the staff who performed the controlled substance reconciliation that morning. She stated that she did report the narcotic count discrepancy	F 755	practice, no discrepancies noted. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur? The Staff Educator provided re-education on April 19th, 2023, regarding administration of liquid narcotics and ensuring accurate count and report discrepancies. The Director of Nursing and or designee will conduct audits 5 times a week x4 weeks, then 3x a week x4 weeks and then weekly for 4 weeks of ordered control substances in liquid form for accuracy. How will the corrective action be monitored to ensure the deficient practice will not recure? The Director of Nursing and or designee will report the audit findings during the Quality Assurance Performance Improvement (QAPI) meeting scheduled for May 25th, 2023, and then monthly x3 months. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads.	

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 _____	04/20/2023

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 755	Continued From page 90	F 755		

for Resident #43's controlled medication [redacted] to the Licensed Practical Nurse Unit Manager (LPN/UM) after surveyor inquiry.

On 04/18/23 at 10:51 AM, the surveyor interviewed the LPN/UM who stated that he was made aware of the controlled medication discrepancy for Resident #43's narcotic medication, [redacted] He further stated that the [redacted] narcotic count indicated that the controlled substance in the bottle should have been [redacted] ml, however there was [redacted] ml in the bottle. He stated that the narcotic medication, [redacted] was [redacted] ml over the amount that it should have been. He stated that he would discuss the issue with the Director of Nursing (DON) so that an investigation could ensue and to see if a new bottle of the medication needed to be ordered from the pharmacy. He confirmed that when the controlled medication reconciliation was performed and a discrepancy was identified in the narcotic count, the discrepancy should have been reported to the unit manager or nursing supervisor so that it could have been investigated by the DON.

On 04/18/23 10:55 AM, the surveyor interviewed LPN #2 who identified herself as the nurse who performed the controlled medication reconciliation that morning (04/18/23) on [redacted]-wing [redacted]. LPN #2 stated that when she performed the narcotic count the morning of 04/18/23 at approximately 6:50 AM with the 11:00 PM - 7:00 AM nurse, she identified that Resident #43's narcotic medication, [redacted] t was [redacted] ml over the correct count. She confirmed that the medication count for [redacted] should have been [redacted] ml but instead was [redacted] ml. She stated that she did not know the 11:00 AM - 7:00 AM nurse's name, but

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 _____	04/20/2023

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 755	Continued From page 91	F 755		

brought it to the other nurse's attention that the narcotic count for the medication [redacted] was [redacted] ml over the amount of what it should have been. She stated that she did not report the discrepancy to the LPN/UM because she did not know she had to report a narcotic discrepancy when it was over the correct amount and thought that she only reported it if it was under the correct amount.

On 04/18/23 at 11:24 AM, the DON stated that the process for a controlled substance discrepancy should have been that the nurse who found the discrepancy should have reported the discrepancy to the nurse manager or nursing supervisor so that an investigation could have been conducted. The DON stated that it was difficult to determine the correct amount for liquid narcotics because the packaging sometimes was delivered under the amount and sometimes it was delivered over the amount. He stated that the accuracy for liquid narcotics count was also difficult to determine because when the nurses pour the medication that it could be off by a couple of milliliters. The DON did confirm with the surveyor that the narcotic count for Resident #43's narcotic medication [redacted] was [redacted] ml over the amount of what it should have been. He confirmed that the nurses should have reported the discrepancy to the nursing supervisor and DON when they discovered it during the controlled substance reconciliation the morning of 04/18/23.

On 04/18/23 at 11:44 AM, the surveyor interviewed the Pharmacy Consultant (PC)who stated that if an error was identified during the controlled medication reconciliation count then it should have been reported to the DON. She continued to explain that it was very difficult to

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 _____	04/20/2023

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 755	Continued From page 92	F 755		

have an exact amount in liquid bottles of narcotics. She stated it was not an "exact science when measuring a liquid" and that it could be off. She stated that a measuring cup was not as accurate as a syringe would be as a form of measurement and added that the amount could also be off if the pharmacy overfilled the medication bottle. The PC did not speak to the pharmacies practicies for delivering the appropaite amount of a narcotic medication to the facility for a resident. She further stated that the narcotic count could very easily be over by [redacted] ml. The PC then stated, "In that big bottle, it could be off in practical use". The PC did not speak to the six rights of medication administration which included the right dose of the medication to be administered regardless if it was in liquid form.

On 04/20/23 at 09:24 AM, in the presence of the survey team, the LNHA stated that she did not know what should have been done when the nurses discovered that there was a discrepancy in the controlled substance reconciliation for Resident #43's narcotic medication, [redacted] The DON stated that the importance of signing out that a narcotic was given and having an accurate record of the narcotic count was to assure there was not a drug diversion and that there was no evidence that the resident missed doses of the medication. The DON and the LNHA did not provide the surveyor with any additional information.

The surveyor reviewed the undated facility policy, "Guidelines for ordering, Receipt, storage, and inventory of Narcotic/Controlled Substance." The purpose of the facility policy is to provide guidelines for the process of a physical inventory check, storage, tracking and documentation of

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 _____	04/20/2023

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 755	Continued From page 93 controlled substances. The procedure section of the policy indicated: -The nursing supervisor will count controlled medications and fill in the appropriate information on the count sheet. The count sheet will be delivered to the floor and the floor nurse would sign off the delivery manifest to signify receipt of medications with the right documented amount or quantity. -Documentation on the count sheet should be done immediately upon removal of medication. It should indicate the quantity/amount removed and remaining quantity and amount. -A narcotic count is done at the end of each shift or when there is a change in the nursing staff. Discrepancies should be reported immediately to the nursing supervisor or manager for investigation. N.J.A.C. 8:39-29.4 (k)	F 755		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documentation it was determined that the facility failed to serve hot and cold foods	F 804	Nutritive Value/Appear, Temperature F804 SS=D	5/22/23

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 _____	04/20/2023

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 804	Continued From page 94 at an acceptable temperature for the residents. This deficient practice was identified for five (5) of five (5) residents who attended a Resident Council (RC) group meeting, and on one (1) of three (3) nursing units, the [redacted] unit, during the lunch meal service on 04/19/23. The deficient practice was evidenced by the following: 1.) On 04/14/23 at 11:04 AM, the surveyor conducted RC with five (5) residents (Resident #30, #47, #56, #72 and #87), who were alert, oriented and regularly attended the RC group meeting. During the RC meeting, 5 out of 5 residents had complaints regarding the temperature of the food. Residents #72 and #87 resided on [redacted] wing located on the [redacted] floor of the facilty and Residents #30, #47 and #56 resided on the [redacted] floor [redacted] unit. They all agreed that the food was cold and told the surveyor that the food was currently only warm because the survey team was at the facility. Resident #47 stated that he/she complained to the Food Service Director (FSD) regarding the temperatures. All five (5) residents stated that every meal was cold. Resident #56 stated that even the soups were served cold. Resident #47 stated that the staff used to utilize the steam tables on the [redacted] floor and the food would be hot, but the facility had stopped utilizing them. He/she further stated that the steam tables on the second floor were still currently not being utilized. 2.) On 04/19/23 at 11:51 AM, the surveyor met the Food Services Director (FSD) in the kitchen at the food tray line steam table. Steam was observed coming off of all of the prepared foods.	F 804	1. How will those residents affected by the deficient practice be corrected. Residents #30, #47, #56, #72 and #87 were identified during Resident Council with concerns regarding temperature of the hot and cold food. Resident Council was held on April 24th, 2023, where the Administrator reviewed the findings from the Annual State Survey to include systemic changes that will be made to ensure appropriate food temperatures when meals are delivered. 2. How will you identify all other residents having the potential to be affected. Residents have the potential to be affected by the deficient practice. 3. What systemic changes will you make to ensure deficient practice doesn't occur again. On April 19th, 2023, the Food Service Director provided re-education to the Food Service Staff on review of the Temperature policy. On May 9th, 2023, the Food Service Director received additional plate warming pellets to assist in maintaining appropriate food temperatures when transporting meal trays. On May 10th, 2023 the Facility ordered a plate warming system to assist in maintaining appropriate food temperatures when transporting meal trays.	

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 _____	04/20/2023

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 804	Continued From page 95 At 11:58 AM, the surveyor and FSD observed [redacted] wing food cart leave the kitchen. The FSD then calibrated his own thermometer in front of the surveyor. In the presence of the surveyor, the FSD took the following food temperatures from the tray line: Gravy: 180 degrees Fahrenheit (F) Sliced roast beef: 140 degrees F The FSD placed clear plastic wrap over the pan of sliced roast beef and placed it into the steamer. The roast beef was light brown in the center with brown edges and appeared thoroughly cooked. During an interview with the surveyor at that time, the FSD stated that the temperature of the roast beef should have been 160-165 degrees F and stated that they had put gravy on top of the meat which would have increased the temperature and kept the food hot. The FSD further stated that it was important to serve the food at the correct temperatures. At 12:08 PM, the FSD removed the sliced roast beef from the steamer, checked the temperature and the thermometer read 192 degrees F. The FSD placed the tray back on the steam table food line. The FSD then took the following food temperatures from the tray line: Ground roast beef: 120 degrees F The FSD placed clear plastic wrap over the pan of ground roast beef and placed the pan into the steamer then continued checking the tray line food temperature. Chicken breasts: 160 degrees F	F 804	The Food Service Director, Dietician and or designee will utilize the Test Tray Evaluation Form to conduct department audits weekly x4 weeks, then 2x a month for 2 months to ensure delivery of meals are at appropriate food temperatures. 4. How will these actions be measured? The Food Service Director or designee will audit the Test Tray Evaluation Form results and report findings during the Quality Assurance Performance Improvement (QAPI) meeting scheduled for May 25th, 2023 and then monthly x3 months. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads.	

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 _____	04/20/2023

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 804	Continued From page 96	F 804		

Pureed roast beef: 150 degrees F

The FSD stated the pureed roast beef should have been between 160 and 165 degrees F. The FSD placed clear plastic wrap over the pan of pureed roast beef and placed the pan into the steamer.

At 12:13 PM, the FSD removed the ground roast beef from the steamer, checked the temperature and the thermometer read 150 degrees F. The FSD placed the ground roast beef back into the steamer. At that time, the surveyor requested to see the food temperature log from lunch service. The FSD stated, "We didn't test yet today." When the surveyor inquired about the A wing cart that already left the kitchen, the FSD acknowledged that the food temperatures were not checked on the A wing cart and that they should have been checked before the cart left the kitchen. The FSD stated that the food line was tested as soon as the food was set up for the first cart and then the cart would have left the kitchen to go to the unit. The FSD further stated that it was important to test food temperatures accurately.

At 12:16 PM, the FSD removed the ground roast beef from the steamer, checked the temperature and the thermometer read 150 degrees F. The FSD placed the pan back into the steamer. The surveyor observed steam coming from the ground roast beef.

At 12:17 PM, the surveyor was joined by another surveyor in the kitchen.

At 12:27 PM, the surveyors observed the FSD utilizing another thermometer. The surveyors informed the FSD that the food temperatures

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 _____	04/20/2023

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 804	Continued From page 97	F 804		

would be taken from a tray delivered to the Saltzman unit.

At 12:32 PM, the FSD removed the pureed ground beef from the steamer, checked the temperature and the thermometer read 180 degrees F. The FSD placed the tray on the steam table and continued to check temperatures.

Mashed potatoes: 204 degrees F
Carrots/green beans 197 degrees F

At 12:38 PM, the FSD removed the ground roast beef from the steamer, checked the temperature and the thermometer read 177 degrees F. The FSD placed the tray on the steam table.

At 12:48 PM, the surveyors observed the kitchen staff plate lunch trays for the Saltzman unit. The plated food was placed on a heated plastic bottom and covered with a plastic lid. The FSD stated that no plate warmers were used that only a bottom plastic pellet warmer was used.

At 01:00 PM, the surveyors observed the test tray placed on the top right row of a covered, plastic food cart.

At 01:04 PM, the food cart was closed and left the kitchen in the presence of the FSD and the surveyors.

At 01:05 PM, the food cart, the FSD, and the surveyors entered the elevator.

At 01:06 PM, the food cart, the FSD, and the surveyors arrived on the Saltzman unit. At that time, the FSD removed the test tray from the cart and checked the temperatures of the plated test

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 _____	04/20/2023

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 804	Continued From page 98 meal tray which revealed the following: Mashed potatoes with gravy- 116 degrees F. Sliced roast beef with gravy- 115 degrees F. Gravy on the plate- 106 degrees F. Tomato soup in plastic cup- 103 degrees F Cranberry juice- 61 degrees F. Peaches 65- degrees F. At 01:09 PM, the surveyors interviewed the FSD who stated that the hot food was to be served over 160 degrees F and that the cold food was to be served below 40 degrees. A review of the facility's undated policy, "Food Temperatures," revealed, Policy: Foods will be cooked, cooled, held, reheated and stored at the proper temperature to minimize the growth of pathogenic bacteria that may result in foodborne illness. Temperature of food will be monitored to ensure safety. Procedure: 3. Temperatures of Time/Temperature Control for Safety (TCS) foods will be recorded at time of service and monitored periodically during meal service. 4. All hot food items must be cooked to appropriate internal temperatures, and held at a temperature of at least 135 degrees F. 6. Temperatures should be taken periodically to assure hot foods stay above 135 degrees F and cold foods stay below 41 degrees F during the holding and serving process. 8. All cold foods should be received at 41 degrees F or less. 9. All hot TCS foods should be received at 135 degrees F or more. NJAC 8:39-17.4 (a)	F 804		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		5/22/23

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 _____	04/20/2023

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 812	Continued From page 99 §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 by: Based on observation, interview and review of facility documentation it was determined that the facility failed to: a.) properly store potentially hazardous foods in a manner intended to prevent the spread of food borne illnesses and b.) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination. This deficient practice was evidenced by the following: On 04/06/23 from 09:34 AM until 10:42 AM, the surveyor toured the kitchen in the presence of the Food Services Director (FSD) and observed the following: 1.) The blue base of the can opener mounted on	F 812	Food Procurement, Store/Prepare F812 SS=E 1. How will those affected by the deficient practice be corrected. No residents were identified as being affected. 2. How will you identify all other residents having the potential to be affected. All residents have the potential to be affected by the deficient practice. The following corrective actions were immediately taken by the Food Service Director: • immediately cleaned the identified	

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 _____	04/20/2023

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 812	Continued From page 100 the counter was observed with brown debris. The FSD acknowledged that it was dirty and stated it should not have been like that. The FSD stated that the can opener got cleaned nightly and that it was missed last night. The FSD then removed the can opener and base from the counter and handed it to the dishwasher to clean. 2.) In the walk-in freezer, on the fourth shelf of a metal rack, there was an opened cardboard box that was marked "best before or use by 10/24/22" that contained four (4), 10 pound frozen packages of reddish brown meat, each individually wrapped in clear plastic. The FSD stated that the ground meat was sent in plastic bags and that he kept the cardboard box to store them. Two of the four packages were marked with a manufacturer's label, "ground beef best before or freeze by 10/24/22." The other two of the four packages had no labels and no use by dates. The FSD acknowledged there were no labels and stated that he assumed the meat was still good and that he could not tell from the packaging how old the meat was but that if he was in doubt that he would throw the meat away. One of the nonlabeled packages of meat had a small hole in the bag with the meat exposed to air. The FSD acknowledged there was a hole in one package of ground meat and stated it should not have been there. The FSD then removed both unlabeled packages of meat and discarded them in the garbage. 3.) The surveyor further observed in the walk in freezer, one opened cardboard box marked tilapia that contained an opened clear plastic bag with eight frozen whitish tan pieces of meat that were exposed to air. The FSD acknowledged that the fish was not stored properly and that the	F 812	blue base of the can opener • immediately disposed of the identified food items in the walk-in-freezer: both unlabeled packages of meat and eight frozen tilapia • immediately removed the identified wet nesting quarter pans for proper drying • immediately discarded the identified undated spices • immediately covered/sealed the identified exposed coffee filters 3. What systemic changes will you make to ensure deficient practice doesn't occur again. On April 6, 2023, the Food Service Director provided re-education to the Food Service Staff. Education focused on review of the following policies: • Cleaning of Can Opener • Food Receiving and Storage • Manual Ware Washing • Dry Good Storage (spices and coffee filters) • Ice machine Cleaning On April 6th, 2023, the Food Service Director implemented a Checklist for kitchen refrigerators/freezers for food packaging integrity, outdated and unlabeled food items, proper cleaning of the can opener and base, wash and dry manual ware appropriately, storage of dry goods and proper ice machine cleaning. On April 7th, 2023, the Food Service Director reviewed and updated the Can Opener Policy to indicate the can opener will be cleaned after each meal service.	

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 _____	04/20/2023

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 812	Continued From page 101 plastic bag and the box should have both been closed. The FSD stated that it was important to store food correctly to prevent freezer burn or contamination. 4.) On the metal clean rack, there were several quarter pans that were wet nested. The FSD acknowledged the wet nesting and stated that the pans should have been dry before they were placed on the rack. 5.) On the spice rack, there was one opened undated 18 ounce jar of paprika and one opened 18 ounce jar of white pepper with an unreadable faded date. The FSD stated it was important to date the spices when they were opened so they would have known if they were still good. The FSD threw the undated spices into the garbage. 6.) On a metal rack with paper products, there was a large, opened, clear plastic bag of coffee filters with the filters exposed and several filters resting on top of the bag. The FSD stated the coffee filters should not have been exposed and that they should have been covered to protect them from dust and contamination. 7.) On the plastic guard on the inside of the ice machine, there was grayish brown debris. The surveyor wiped the area with a paper towel and the debris was observed on the towel. The FSD acknowledged the debris and stated that it should not have been there and that it was important that the ice machine was cleaned so that no one got sick. Review of the facility's policy, "Cleaning Instructions: Can Opener," dated 2019, revealed, Policy: The can opener will be cleaned after each	F 812	The Food Service Director re-educated the Food Service Staff on the updated policy. The Food Service Director implemented a sign off sheet for cleaning the can opener and base reflecting the new policy. The Food Service Director, Dietician and or designee will utilize the new Checklist form to conduct weekly department audits weekly x4 weeks, then 2x a month for 2 months to ensure proper disposal of outdated items and proper labeling of items, proper cleaning of can opener and base, wash and dry manual ware appropriately, storage of dry goods and proper ice machine cleaning. 4. How will these actions be measured? The Food Service Director or designee will audit the Checklist results and report findings during the Quality Assurance Performance Improvement (QAPI) meeting scheduled for May 25th, 2023, and then monthly x3 months. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads.	

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 _____	04/20/2023

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 812	Continued From page 102 use. Procedure: 1.b. Clean the base thoroughly with hot detergent water. Be sure to remove all food particles from the blade and base. Sanitize, Air dry, Reassemble. Review of the facility's policy, "Food Receiving and Storage," effective date 03/19/17, revealed, Procedure: 7. All foods stored in the refrigerator or freezer will be covered, labeled, and dated (Use by" date.) Review of the facility's undated policy, "Manual Ware Washing," revealed, Procedure: 6. After washing, rinsing and sanitizing, all wares will be air dried prior to storage. Review of the facility's undated policy, "Dish Machine," revealed, Procedure: 6. Dishes, pots and pans should never be wet nested. Review of the facility policy, "Ice Machine-Operation and Cleaning," dated August 1, 2017, revealed Procedure: III. Sanitation of Equipment a. No less than every six months and or as needed ... Review of the facility document, "Ice Machine Maintenance Checklist, Kitchen" revealed the last line with written documentation: Date: marked 1/18/23, Time: left blank, Location: marked kitchen, Cleaned: marked "Y", Sanitized: marked "Y", Staff Initials: marked R.O. No policies provided for spices or coffee filters. NJAC 8:39 17.2(g)	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		5/22/23

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 _____	04/20/2023

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 880	Continued From page 103 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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 _____	04/20/2023

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 880	Continued From page 104 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation it was determined that the facility failed to: a.) ensure that an [redacted] was stored in a manner to prevent the spread of infection for a resident, (Resident #63) one (1) of two (2) residents reviewed for [redacted] care, b.) provide appropriate infection control practices to prevent the spread of infection during one of one [redacted] treatment observation for, (Resident #6) one of two residents reviewed for	F 880	F880 INFECTION PREVENTION AND CONTROL What corrective action will be accomplished for those residents affected by the deficient practice? Resident #63's catheter was replaced without any complications. Nurse Educator provided 1:1 education to the identified treatment nurse on April 14,	

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 _____	04/20/2023

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 880	Continued From page 105 [redacted], and c.) provide appropriate hand hygiene while passing out food to three unsampled residents during the lunch meal pass observation, observed on one of three (3) resident dining rooms, the [redacted] unit. This deficient practice was evidenced by the following: 1.) On 04/14/23 at 11:29 AM, the surveyor observed Resident #63 lying in bed in his/her room. The surveyor observed that the resident's [redacted] was attached to the bed frame and the [redacted] to the resident's [redacted] was in direct contact and touching the floor in the resident's room. The surveyor further observed [redacted] in the [redacted]. On 04/18/23 at 12:12 PM, the surveyor observed the resident in bed in his/her room. The resident told the surveyor that he/she had the [redacted] to their [redacted] y created [redacted] changed two days ago. The resident lifted his/her [redacted] and showed the surveyor the [redacted]. At that time, the surveyor further observed that the resident's [redacted] was attached to the bed frame and the [redacted] to the [redacted] was in direct contact with the floor in the resident's room. The surveyor observed [redacted] throughout the [redacted]. The surveyor reviewed the electronic medical record for Resident #63.	F 880	2023, with return demonstration on proper hand hygiene during patient care and treatment. The treatment cart was immediately sanitized, and any open dry dressing/supplies was immediately discarded. Nurse Educator provided 1:1 education to the identified C.N.A. on April 19th, 2023, on proper hand hygiene upon return to the facility for the C.N.A.'s next scheduled shift. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the same deficient practice. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur? The Director of Nursing and the Staff Educator began providing education to nursing staff on April 14, 2023, regarding infection control with emphasis on proper hand washing / hand hygiene in the prevention of infection and cross contamination during patient care, treatments and meal service, and proper management and maintenance of [redacted] Staff Educator and or designee will observe 5 nurses weekly x4 weeks, then 3 nurses 3x a week for four weeks and	

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 _____	04/20/2023

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 880	Continued From page 106 A review of the resident's Admission Record (an Admission Summary) reflected that the resident had resided at the facility since [redacted] and had diagnoses which included but were not limited to [redacted] and [redacted] A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated, [redacted] reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident was cognitively intact. A further review of the resident's MDS - [redacted] indicated that the resident had an [redacted] A review of the resident's [redacted] Order Summary Report reflected a Physician's Order (PO) dated [redacted], to provided [redacted] every shift, document [redacted], and [redacted] must be off floor. A review of the resident's [redacted] Treatment Administration Record (TAR) revealed a PO dated [redacted], to provide [redacted] care every shift, document [redacted], and [redacted] must be off floor. A further	F 880	then 3 nurses weekly for 4 weeks to ensure compliance with hand washing and hand hygiene protocols during treatments. Staff Educator and or designee will observe 5 nursing staff x4 weeks, then 3 nursing staff 3x a week for four weeks and then 3 nursing staff weekly for 4 weeks to ensure that staff are compliant with hand washing and hand hygiene protocols during patient care and meal pass. How will the corrective action be monitored to ensure the deficient practice will not recure? The Director of Nursing or designee will report the audit results during the Quality Assurance Performance Improvement (QAPI) meeting scheduled for May 25th, 2023, and then monthly x3 months. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director and Department Heads.	

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 _____	04/20/2023

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 880	Continued From page 107 review of the resident's [redacted] TAR indicated that the nurses were signing for the care of the [redacted] every day, evening, and night shift from [redacted], through [redacted]. A review of Resident #63's Care Plan reflected a focus area that the resident had an [redacted] in [redacted] related to [redacted] due to [redacted]. The goal of the resident's Care Plan was the resident would not develop [redacted] such as [redacted], and [redacted]. The interventions in the residents Care Plan included patient teaching training on [redacted] management and infection control as appropriate. On 04/18/23 at 01:08 PM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that she took care of the resident regularly on the 7:00 AM - 3:00 PM shift and the resident was [redacted], [redacted]. The CNA told the surveyor that the resident had a [redacted], and she was responsible for emptying the [redacted] form the [redacted]. The CNA further stated that the [redacted] was never to touch the floor because it was unsanitary. On 04/18/23 at 01:12 PM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that the resident had a [redacted] and was [redacted] to [redacted]. The LPN further stated that the [redacted] to the resident's [redacted] should never be in contact with the floor for infection control purposes. On 04/18/23 at 01:20 PM, the surveyor	F 880		

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 _____	04/20/2023

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 880	Continued From page 108 interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that the [redacted] to an [redacted] should never touch the floor for infection control purposes and to prevent the spread of infection. A review of the facility's undated policy, "Foley [redacted] Utilization Policy and Procedure," indicated that [redacted] would be stored in a privacy bay for infection control and privacy. The facility's [redacted] Utilization Policy and Procedure did not speak infection control practices in relation to the [redacted] touching the floor. 2.) On 04/06/23 at 12:07 PM, the surveyor observed Resident #6 seated in a wheelchair in the dining area awaiting lunch. The resident did not have [redacted] on and had a [redacted] on the [redacted] and a [redacted] on the [redacted]). The resident informed the surveyor that an [redacted] was taken of the [redacted] the day prior and that the [redacted] on the [redacted] was infected. The resident further stated that a [redacted] care specialist came to the facility every [redacted], and the dressing was changed daily by nursing staff. On 04/11/23 at 11:24 AM, the surveyor observed Resident #6 seated in a wheelchair, this time wearing socks. The resident again informed the surveyor that dressing changes to the wounds on their feet were changed daily. The surveyor reviewed the medical record for Resident #6. A review of the resident's Admission Record reflected that the resident had resided at the	F 880		

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 _____	04/20/2023

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 880	Continued From page 109 facility since [redacted] and had diagnosis which included but were not limited to type two [redacted]. A review of the resident's most recent quarterly MDS, dated [redacted] reflected that the resident had a BIMS score of [redacted] which indicated the resident had [redacted]. A further review of the resident's MDS, [redacted] - Skin Conditions indicated the resident had one [redacted]. A review of the resident's [redacted] Order Summary Report reflected a PO dated [redacted] to cleanse the [redacted] with [redacted] used to [redacted], apply [redacted] between the [redacted] and [redacted] to help [redacted] and [redacted] during [redacted] on [redacted]), apply [redacted] (a prescription medication used to treat [redacted] Cover with dry protective dressing, [redacted] (a medication used to promote [redacted] and [redacted]. A review of the resident's [redacted] and [redacted] TAR revealed the PO dated [redacted] to perform the [redacted]. A further review of the TAR indicated that day shift nurses were performing [redacted] from the start date of [redacted] through [redacted]. A review of Resident #6's Care Plan reflected a	F 880		

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 _____	04/20/2023

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 880	Continued From page 110	F 880		

focus area that the resident had a stage three pressure ulcer to the [redacted] dated [redacted]. The goal of the resident's Care Plan was the resident's [redacted] would show signs of [redacted] and remain [redacted]. The interventions in the residents Care Plan included but was not limited to, administer medications as ordered, administer treatments as ordered, and follow facility policies/protocols for the [redacted] of [redacted].

On 04/14/23 at 10:12 AM, during a wound care observation performed by the LPN, the surveyor observed the following:

The LPN brought the wound treatment cart to Resident #6's room door, she opened the cart and brought into the resident's room a container of disinfectant wipes, which she set down on the dresser next to the television and without using gloves, used a wipe from the container to disinfect the bedside table.

The LPN then disposed of the wipe, went into the restroom, and washed her hands lathering with soap for 20 seconds (timed by the surveyor using a stopwatch). She then donned (put on) disposable gloves and proceeded to the treatment cart to prepare and gather all the treatment supplies. The LPN gathered a disposable barrier pad to place on the tray table, on which she placed an unopen full package of 4x4 clean gauze pads, skin prep pads, [redacted]s solution bottle, single use sterile [redacted] tubes of [redacted] which were in a plastic bag, one 4x4 sterile border gauze dressing, several wooden medication application sticks, and a bottle of [redacted]

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 _____	04/20/2023

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 880	Continued From page 111	F 880		

The LPN then opened the 4x4 clean gauze pack and placed six small stacks of gauze on the barrier pad, leaving approximately half the pack in the original packaging. She then proceeded to elevate the resident's [redacted] and placed a hard [redacted] behind the [redacted] to keep the heels accessible. The LPN then doffed (took off) her gloves, disposed of them and returned to the restroom to wash her hands again. This time, the LPN lathered her hands with soap and water for 13 seconds.

She then donned new gloves, opened the calcium alginate, skin prep pad, and 4x4 sterile border dressing. The surveyor observed the LPN remove the wound dressing on the resident's [redacted]. She disposed of the used dressing, and without changing gloves or performing hand hygiene, grabbed the bottle of [redacted] solution, poured the [redacted] solution on the six 4x4 stacks of gauze, put down the bottle, picked up a stack of [redacted] saturated gauze, dabbed the resident's [redacted] to clean it, and repeated this step with the two remaining saturated stacks of 4x4 gauze. The LPN then patted the [redacted] dry with the three remaining dry stacks of gauze.

The surveyor further observed the LPN doff (remove) her gloves, and without performing hand hygiene or using ABRS, donned a new pair of clean gloves, applied the [redacted] around the wound, disposed of the used [redacted] and doffed and disposed of the gloves. At this time the LPN used the ABHS to sanitize her hands and stated to the surveyor, "I forgot to sanitize between glove changes."

Then she donned new clean gloves, opened one

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 _____	04/20/2023

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 880	Continued From page 112	F 880		

tube of [redacted] and applied a small amount directly onto an application stick and while lifting the resident's [redacted] higher with one hand, applied the [redacted] to the [redacted] disposed of the stick, applied the [redacted] pad and covered the [redacted] with the 4x4 border dressing.

The LPN then assessed the resident's pain level to which the resident replied they felt, "alright." Without changing gloves and performing any hand hygiene, the LPN picked up the open [redacted], closed it, placed it into the plastic bag with the [redacted] and closed the [redacted] bottle which was left uncovered during the process. With the same gloves still on, she collected the trash bag, tied it and placed the trash bag on the floor. The LPN then repositioned the resident's [redacted] by removing the [redacted]

The LPN still had on the same gloves, no glove change or hand hygiene was performed. The surveyor further observed the LPN gather the remaining unused supplies including the half-used pack of 4x4 gauze, [redacted] bottle, and tubes of [redacted]. She left these supplies on the tray table, and proceeded to use a pen to date and label the dressing that was just applied to the resident's [redacted] Next, she doffed the gloves, and without performing hand hygiene or wiping any containers, while holding the used gloves balled up in one hand, picked up the [redacted] bottle, opened the pack of clean 4x4 gauze, and the bag containing the [redacted] tubes of [redacted] and brought them back to the treatment cart and placed them in their drawers and disposed of the dirty gloves.

Without performing hand hygiene, donned new gloves, disposed of remaining used treatment items including the barrier pad on the tray table

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 _____	04/20/2023

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 880	Continued From page 113	F 880		

into a second trash bag, pulled another disinfecting wipe from the container left in the resident's room and wiped the tray table. Then, without disinfecting the container, placed the disinfecting wipes container into the treatment cart drawer. The LPN then doffed her gloves, picked up the two trash bags, carried them down the hall to the waste room, disposed of them in the waste, and entered the nurse's office across from the waste room to wash her hands. She washed her hands by lathering for 17 seconds.

At this time, 10:34 AM, the surveyor interviewed the LPN. The LPN stated that she realized she did not perform hand hygiene in between glove changes and stated she was "supposed to." She also stated hand washing should include lathering with soap for "30 seconds to a minute" and that time is kept by "counting in your head." The LPN further acknowledged that only supplies needed for the wound treatment were to be brought into the resident's room and any extra supplies should have been left in the cart. The LPN further stated that once the supplies were brought into the room, the supplies should not be brought back and placed into the cart as it would contaminate the cart, which is used for multiple resident's treatments. She stated the remaining 4x4 gauze should have been thrown out or left in the room, and the bottles of [redacted] and disinfectant wipes should have been wiped down with disinfectant "before and after putting back into the cart."

On 04/14/23 at 11:11 AM, the surveyor interviewed the Director of Nursing (DON) who confirmed that washing hands by lathering for 13 and 17 seconds is not enough time and should be 20 to 30 seconds. The DON further stated that reusable bottles of medication and solution used

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 _____	04/20/2023

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 880	Continued From page 114	F 880		

during [redacted] treatment should be wiped down with disinfectant prior to returning to the treatment cart, and any unused disposable clean supplies such as remaining 4x4 gauze should be disposed of and not returned to the cart. The DON was in agreement that going from a dirty area to a clean area was contamination and could, "lead to infection." The DON also stated that hand sanitizing or hand hygiene should be performed in between each glove change during [redacted] care.

A review of the facility's "Dressings - Application and Technique" policy with a revised date 01/01/2017 included under the section labeled "Procedure" subsection "General" to "wash hands before and after each procedure and put on gloves ... gather equipment needed." Under subsection "Application of Dressing Clean Technique" included: "Bring all dressings, solutions, and items to be used and place on the prepared work surface ... don non-sterile gloves ...open packages and cut tape. Place initials and date on a piece of tape or on the dressing ...remove dressing(s) and discard into plastic bag ... remove and discard non-sterile disposable gloves in plastic bag at bedside. Wash hands and reapply non-sterile disposable gloves. Proceed with cleansing of [redacted] Clean [redacted] with [redacted] or prescribed cleanser. Pat the tissue dry with clean gauze pad ... remove and discard non-sterile disposable gloves in plastic bag at bedside. Wash hands and reapply non-sterile gloves." Apply barrier film to peri-wound, apply topical agents (medications) as prescribed, "discard gloves if using an adhesive dressing or tape remove gloves first."

A review of the facility's undated policy, "Hand Washing/Hand Hygiene," included under the

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 _____	04/20/2023

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 880	Continued From page 115	F 880		

section labeled "Procedure" "1. When: a. Before and after (it may be necessary to perform hand hygiene between treatments to prevent cross contamination of sites) i. Each direct care contact ...
c. After:
i. The handling of actual or potentially biohazardous materials
ii. Removing protective gloves...
2. How: a. hand washing technique:...
ii. Special: wash hands and lather for no less than 30 seconds when caring for a resident known to be infected with virulent or potentially virulent organisms. Antiseptic soap is to be used."

3.) On 04/06/23 at 12:41 PM, the lunch food cart arrived on the [redacted] unit.

At 12:43 PM, the surveyor observed a CNA cutting up an unsampled resident's meal with the resident's silverware, touched the resident's right hand to place the fork in it, and then assisted to remove a cup from the resident's left hand. No hand hygiene was observed before or after assisting the resident.

At 12:44 PM, the CNA touched another unsampled resident's wheelchair and pushed the resident up to the table. The CNA then locked the resident's wheelchair brakes. No hand hygiene was observed before or after assisting the resident.

At 12:45 PM, the CNA approached the food cart, took a tray from the cart and touched several food trays in the cart while looking for a resident's tray. No hand hygiene was observed before or after touching the food cart or trays.

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 _____	04/20/2023

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 880	Continued From page 116	F 880		

At 12:46 PM, the CNA handed four trays to another CNA to place into a separate food cart. The CNA then touched the top of the food cart, closed the food cart, wheeled the cart towards the door, then wheeled the cart back into the dining area. No hand hygiene was observed before or after touching the food cart.

At 12:47 PM, the CNA removed an unsampled resident's meal tray from the food cart and placed the tray in front of the resident. The CNA removed the food lid, opened the plastic cup, opened and placed a tea bag into the cup, opened two sugar packets and placed them into the cup. The CNA then opened a straw and placed it into the resident's apple juice and then replaced the lid on the plate. The resident was observed drinking from the straw. No hand hygiene was observed before or after assisting the resident.

At 12:56 PM, the surveyor interviewed the CNA who stated that it was a team effort to pass out the trays and collect the trays and that some CNAs would feed the residents in their rooms while some would feed the residents in the dining room. The CNA stated the process for hand hygiene was to hand wash prior to helping the residents. The surveyor informed the CNA of the observations during the tray pass and that no hand hygiene was observed. The CNA acknowledged that no hand hygiene was performed between residents and stated that hand hygiene should have been performed, "every time you do something, in between each resident, the whole time you are helping, every time." The CNA stated it was important to perform hand hygiene because hands held bacteria and were how germs were shared.

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 _____	04/20/2023

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 880	Continued From page 117 On 04/11/23 at 11:52 AM, the surveyor interviewed the LPN on the [redacted] unit. The LPN stated that hand hygiene was performed between each resident contact and between each resident's meal tray pass. The surveyor informed the LPN of the CNA observations during the tray pass on [redacted] and that no hand hygiene was observed. The LPN acknowledged that was not the correct way to pass trays and that it was important for infection control that hand hygiene was done with any resident contact. On 04/11/223 at 11:55 AM, the surveyor interviewed the LPN/Acting Unit Manager (LPN/AUM) on the [redacted] unit. The LPN/AUM stated that hand hygiene was performed between every resident and that hand hygiene was performed during meal tray pass. The surveyor informed the LPN/AUM of the CNA observations during the tray pass on [redacted] and that no hand hygiene was observed. The LPN/AUM stated that it was important for infection control that hand hygiene was done before and after contact with each resident and when collecting the food trays. On 04/11/23 at 02:00 PM, the surveyor interviewed the LPN/Infection Preventionist/Staff Educator (LPN/IP/SE) who stated that hand hygiene should have been performed after any caregiving, when gloves were removed, when food trays were passed, after a resident was fed, and when a resident was pushed in a wheelchair. The surveyor informed the LPN/IP/SE of the CNA observations during the tray pass on [redacted] and that no hand hygiene was observed. The LPN/IP/SE stated that the CNA should have performed hand hygiene "during all of that," and that hand hygiene was important to reduce the	F 880		

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 _____	04/20/2023

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 880	Continued From page 118 spread of infection. On 04/12/23 at 11:37 AM, in the presence of the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the surveyor informed them of the CNA observations during the tray pass on [redacted] and that no hand hygiene was observed. During an interview with the DON at that time, the DON stated that hand hygiene was the best way to prevent infection and cross contamination and that it was the best practice for infection control. The DON stated that the CNA touched areas that would have exposed his hands to a dirty environment or soiled surfaces and that hand hygiene should have been performed before and after any type of direct contact with a resident. A review of the facility's undated policy, "Hand Washing/Hand Hygiene," revealed Policy: Since hand washing/hand hygiene has been identified as the single-most effective means of preventing and controlling the spread of infection, it is the policy of this facility that all staff carry out hand washing or hand hygiene techniques in accordance with facility procedures to decrease bacteria or other possible pathogenic organisms on the hands that could cause disease. The Hand Washing/Hand Hygiene Policy further indicated, "Procedure: 1.a. Before, and after (it may be necessary to perform hand hygiene between treatments to prevent cross contamination of sites i. Each direct care contact. ii. The preparation and handling of foods. b. Before: i. Handling sanitized equipment/materials, e.g., clean linens, clean dishes." NJAC 8:39-19.4 (a)1(m)(n);27.1(a)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060402	A. BUILDING: _____ B. WING _____	04/20/2023

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) COMPLETE DATE
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift, as mandated by the State of New Jersey. This was evident for 5 of 14 day and was evidenced as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were	S 560	Staffing Levels S560 What corrective action will be accomplished for those residents affected by the deficient practice? No residents were identified. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the deficient practice. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur.	5/22/23

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

Electronically Signed | 05/10/23

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060402 Y1	A. Building B. Wing Y2	6/8/2023 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 State surveyor to show those deficiencies previously reported 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 State Survey Report (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 S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/22/2023	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	
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	
4/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060402	A. BUILDING: _____ B. WING _____	04/20/2023

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) COMPLETE DATE
S 560	Continued From page 1 effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 03/19/2023 to 03/25/2023 and 03/26/2023 to 04/01/2023 for the 04/20/2023 standard survey, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below: The facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -03/19/23 had 14 CNAs for 129 residents on the day shift, required 16 CNAs. -03/22/23 had 14 CNAs for 128 residents on the day shift, required 16 CNAs. -03/24/23 had 14 CNAs for 128 residents on the day shift, required 16 CNAs. -03/25/23 had 15 CNAs for 128 residents on the day shift, required 16 CNAs.	S 560	On April 20, 2023, the Administrator provided re-education to the Director of Nursing and Staffing Coordinator on the minimum staffing requirements by shift for nursing by the Department of Health. The Administrator, Director of Nursing and Staffing Coordinator will meet weekly to review staffing levels for the week, open positions, and recruitment efforts. The facility will focus on recruitment and retention including but not limited to, use of web-based recruitment advertising, contract utilization, sign on bonuses and referral bonuses, job fairs, shift differentials and employee moral incentives. The Staffing Coordinator will utilize the Recruitment Report to track and trend recruitment efforts weekly x4 weeks, then 2x a month for 2 months. How will the corrective action be monitored to ensure the deficient practice will not recur. The Administrator and or Designee will review and report the audit results during the Quality Assurance Performance Improvement (QAPI) meeting scheduled for May 25th, 2023, and then monthly x3 months. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director, and Department Heads.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060402	A. BUILDING: _____ B. WING _____	04/20/2023

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) COMPLETE DATE
S 560	Continued From page 2 -03/31/23 had 14 CNAs for 123 residents on the day shift, required 15 CNAs. On 04/19/23 at 11:15 AM, the surveyor interviewed the Staffing Coordinator/Human Resources (SC/HR) who stated that she was aware that some days the facility was short staffed. She explained to the surveyor that this was due to nursing and CNA call outs and not being able to get replacements. She stated that the facility had contracts with agency staffing to attempt to replace the CNA and nurses when they experienced call outs. She further stated that the facility had an in-house agency which offered more money for the staff members. The SC/HR told the surveyor that she would ask staff members to stay and would provide them with overtime pay if they needed replacements. She stated that to entice employees to work, the facility would offer a small bonus or gift cards and that the facility had a recruitment program through employment websites. She continued to explain that salaries were an issue because the facility had a union and because they had a union, contract employees would get raises and increases based on that contract. She stated that if a newly hired employee decided to enroll in the union then the pay could not be negotiated because the pay rates were set in the union contract. NJAC 8:39-5.1(a)	S 560		