STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315068	A. BUILDING _____ B. WING _____	C 10/21/2022

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

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F 000	INITIAL COMMENTS Complaint #: NJ148986, NJ149800, NJ150375, NJ151998, NJ153975, NJ155732, NJ156866, NJ157369, NJ157664, NJ158078 Census: 138 Sample Size: 13 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey. Survey dates: 10/20/2022-10/21/2022	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609		12/16/22

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

Electronically Signed | 12/09/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 609	Continued From page 1 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ157369 Based on observation, interviews, record review, document review, and facility policy review, the facility failed to ensure an allegation of staff-to-resident [redacted] abuse was reported to the state survey agency (SSA) within two hours and failed to report the results of the facility's investigation within five days for 1 (Resident # 5) of 3 sampled residents reviewed for abuse. Findings included: Review of an "Admission Record" revealed the facility admitted Resident #5 on [redacted] with diagnoses which included [redacted] Review of a quarterly Minimum Data Set (MDS), dated [redacted] revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating the resident was [redacted]. The MDS indicated the resident required [redacted] with [redacted]. The MDS revealed the resident was at risk for development of [redacted] but had no existing [redacted] at the time of the assessment.	F 609	What corrective action will be accomplished for those residents affected by the deficient practice? All allegations of abuse, neglect, exploitation, mistreatment, including injuries of unknown source and misappropriation of resident property by Resident #5 will be reported immediately and or no later than 2 hours after the allegation is made. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be take? All residents have the potential to be affected by the same deficient practice. Any allegation made by a resident and/or care partner, of abuse, neglect, exploitation, mistreatment, including injuries of unknown source and misappropriation of resident property will be reported immediately to Department of Health Hotline no later than 2 hours after the allegation is made. What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not	

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F 609	Continued From page 2 Review of a care plan, dated as revised [redacted], revealed Resident #5 had an activities of daily living (ADL) self-care performance deficit due to a diagnosis of [redacted]. According to the care plan, the resident had a strong desire to be [redacted] regarding their care and would try to do their [redacted] care after staff had already performed care, despite education on the proper way to do [redacted] care. Interventions included to encourage increased participation with ADLs as tolerated, praise efforts, and communicate with the therapy department. The care plan further indicated Resident #5 could be [redacted] to care (including assessments, medications, fluids) due to adjustment to placement and medical diagnosis. Review of an untitled facility document dated [redacted] revealed the US FOIA (b)(6) [redacted] typed a description and investigation of an event involving Resident #5. The report indicated the event date was [redacted] and the report date was [redacted]. The report revealed that on [redacted] staff informed the [redacted] that Resident #5 had complained about a nurse who had been rough and "forced" the resident to be checked for [redacted], despite the resident saying "no." The report indicated the nursing staff stated Resident #5 mentioned the event to them on [redacted] but was "just verbalizing care" and "did not want to report it to the nursing supervisor." The report indicated the resident "did not want anything reported to any agency" but wanted administration to be aware and, "look into it." Further review of the report revealed the following:	F 609	recur? The Director of Nursing and or Designee began re-education of staff on October 25, 2022 on timely (within 2 hours) reporting of allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown origin reported by any resident/patient and/or care partner. Process will also be followed by Nursing Supervisor and or Designee on conducting an initial investigation, notification of nursing administration and reporting to Department of Health Hotline no later than 2 hours after the allegation is made. Re-education to RN/LPN's focused on the following: a.Definition of abuse, neglect, exploitation, mistreatment, injuries of unknown source and misappropriation of resident property. b.Reporting within 2 hours to appropriate Government agencies. c.Education/encouragement of residents / care partners to report concerns immediately or as soon as possible. How will the corrective action be monitored to ensure the deficient practice will not recur? Nurse Managers and Supervisors will notify the Director of Nursing and/or the Assistant Director of Nursing regarding allegations of abuse and neglect, the DON or Designee will call in the allegation	

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F 609	Continued From page 3 - The report indicated the [redacted] saw Resident #5 in bed in the resident's room. The resident stated the nurse who did the [redacted] was rude and "rough" with the resident, '[redacted]s [redacted]." The resident stated they did not want the assessment done while in the shower room but wanted it to be completed in their own room. Resident #5 stated when the nurse "insisted to have the assessment in the shower room," the resident admitted yelling at the nurse. The [redacted] checked the resident's arms, where the resident stated they were [redacted]," and there were no signs of [redacted] noted. The report indicated that Resident #5 offered no explanation as to why they refused to have the assessment while still in a shower bed in the shower room, which would be the best time and least difficult for the resident and the nurse. The report indicated that Resident #5 appeared quite agitated just being asked the question. The resident reported that the aide who gave the shower witnessed everything and saw how "rude" the nurse was. The resident stated that the aide was "good" and that the resident liked the aide. - The typed report indicated the [redacted] interviewed Licensed Practical Nurse (LPN) #5 and asked her to write a statement about the incident. LPN #5 denied being rough but admitted that Resident #5 initially refused the [redacted]. However, after explaining the procedure, she was under the impression that Resident #5 agreed to the assessment. LPN #5 stated she understood that Resident #5 had the right to refuse but reiterated that she had to at least attempt to explain the importance of clinical procedures and convince the resident. She was also under the impression that Resident #5 relented to a quick [redacted] check after the explanation, as the resident also initially	F 609	to the Department of Health within two hours of the allegation. A log of allegations will be maintained in the DON office. The Director of Nursing and or Designee will audit the logs for compliance to the 2-hour reporting window weekly x4, then 2x a month for 3 months. The Director of Nursing and or Designee will report results in the monthly nurse management meeting and to the Quality Insurance Performance Improvement Committee for 3 months. The QAPI meeting is attended by the NHA, DON, Medical Director, and Department Heads.	

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F 609	Continued From page 4	F 609		

refused night medication but ended up being convinced to take them. The report indicated that LPN #5 denied that Resident #5 told her the resident wanted to have the assessment done in their room. She also stated that Resident #5's negative demeanor towards her continued when she was giving night medications, as the resident initially refused the medications but was informed of the importance of the [redacted] medications and agreed to take them.

- The report indicated agency Certified Nursing Assistant (CNA) #6 admitted she was the aide who gave Resident #5 a shower on the date of the incident with LPN #5. CNA #6 stated that after the shower, LPN #5 entered the shower room to do a [redacted] on Resident #5, which the resident refused. LPN #5 tried to explain the importance of getting Resident #5 assessed and that it would not take long, and while they attempted to turn Resident #5, the resident became very [redacted] and started [redacted] at LPN #5. CNA #6 stated LPN #5 was not argumentative but "very patient." CNA #6 also stated she did not hear Resident #5 say that they wanted to have the assessment in their room.

- The report revealed the facility's investigation did not substantiate that LPN #5 was "rough and rude." The report indicated Resident #5 had a history of refusing care and would blame staff for negative outcomes such as [redacted]) and [redacted]. The report did not indicate the resident's allegation and the facility's subsequent investigation were reported to the SSA.

Observation on 10/20/2022 at 11:30 AM revealed Resident #5 sitting in bed in their room. There

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F 609	Continued From page 5 were NJ Ex Order 26.4b1. During an interview at this time, Resident #5 indicated they reported to the SSA that a nurse had not honored the resident's wishes to decline an assessment of a [redacted] to the resident's [redacted] in the shower room. CNA #6 and LPN #5 were unavailable for an interview during the complaint investigation. They were no longer employed at the facility. During an interview on 10/21/2022 at 2:22 PM, the US FOIA (b) stated when the NJ Ex Order 26.4b1 was brought to his attention concerning Resident #5, he immediately started an investigation. He indicated the allegation was not substantiated because NJ Ex Order 26.4b1 were observed during the immediate assessment of the resident's NJ Ex Or. In addition, CNA #6, who was present in the shower room, indicated Resident #5's description of the events in the shower room was inaccurate. The US FOIA (b) added that according to CNA #6, LPN #5 was gentle with the resident and did not forcefully assess Resident #5. He indicated the resident was care planned for resisting care, and staff was trained to educate the resident about the potential negative outcome of resisting care. The US FOIA (b) indicated that after the completion of his investigation, he did not report the alleged NJ Ex Order 2 to the SSA. He indicated that, per the facility's policy, he should have completed a 24-hour and 5-day report and faxed the reports to the state. During an interview on 10/21/2022 at 2:30 PM, the US FOIA (b)(6) reported she expected abuse reports to be completed and filed with the SSA timely. Review of an undated facility policy titled,	F 609		

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F 609	Continued From page 6 "Resident Abuse and Neglect Reporting," revealed, "6. The Administrator, or his/her designee, will notify the following persons or agencies of such incident: a) Ombudsman-upon allegation. b) State Licensing and Certification Agency. c. Resident Representative. d) Law Enforcement Officials, as appropriate (See Peggy's Law). An alleged violation of abuse, neglect, exploitation, and misappropriation of resident property will be reported to the appropriate agency but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury. b. Twenty-four (24) hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury. 7. The Administrator or his/her designee must complete an incident report/investigation and obtain a written, signed, and dated statement from the person reporting the incident. 8. A completed copy of the Incident Report and written statements from witnesses, if any, must be provided to the Administrator within twenty-four (24) hours of the occurrence of such incident. An immediate investigation will be made and a copy of the findings of such investigation will be provided to the Administrator within three (3) working days of the occurrence of such incident." New Jersey Administrative Code § 8:39-5.1(a)	F 609		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		12/16/22

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F 656	Continued From page 7 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ148986	F 656	What corrective action will be accomplished for those residents affected	

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F 656	Continued From page 8 Based on record review, interviews, and facility policy review, the facility failed to ensure a care plan was developed to address the care and monitoring necessary related to the need for [redacted] (insertion of a catheter into the bladder on an [redacted] for 1 (Resident #2) of 3 sampled residents who required [redacted] Findings included: Review of an "Admission Record" revealed Resident #2 had diagnoses which included [redacted] Further review revealed the facility discharged the resident on [redacted]. Review of an admission Minimum Data Set (MDS), dated [redacted] revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated NJ Ex Order 26.4b1 [redacted]. The MDS indicated the resident required [redacted] with all activities of daily living (ADLs) [redacted]. According to the MDS, the resident required [redacted] Review of a care plan, dated [redacted], revealed Resident #2 had an ADL [redacted] related to [redacted] and [redacted] Further review of the resident's entire comprehensive care plan revealed it did not address the resident's need for [redacted]. Review of an "Order Listing," in Resident #2's	F 656	by the deficient practice? Patient #2 is discharged. 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? Resident's / Patients admitted or started or have a current treatment order for [redacted] have the potential to be affected by this deficient practice. There are currently no residents with treatment orders for [redacted] 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 October 25, 2022 to RN/LPNs on the following: a.Individualized Plan of Care: initiation, access, and updates. b[redacted] and [redacted]. c.Nursing leadership - which includes but not limited to the Director of Nursing, Assistant Director of Nursing, I.P., Nurse Managers and Nursing Supervisors and/or designees are to monitor admissions to the facility and ensure that an individualized plan of care is completed. d.All residents/patients with current [redacted] and/or [redacted] were reviewed for	

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F 656	Continued From page 9 electronic medical record revealed a physician's order dated [redacted] for straight NJ Ex Order 26.4b1 times daily every six hours. During an interview on 10/21/2022 at 12:01 PM, the US FOIA (b)(6)) stated he was the one who should have completed a care plan for Resident #2's [redacted] care and had "missed it." The [redacted] indicated there should have been a care plan for Resident #2's [redacted] During an interview on 10/21/2022 at 5:32 PM, the US FOIA (b)(6) stated she expected Resident #2's care plan to address the use of a [redacted] to avoid further [redacted]. Review of an undated facility policy titled, "Baseline Care Plan Policy and Procedures," revealed, "The purpose of the facility Baseline Care Plan Policy is to outline a process for development of an initial person-centered care plan that will provide instructions for care of the resident." The policy also indicated, "The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan."	F 656	appropriate plan of care. A Chart (EMR) Audit form will be utilized to ensure that patients/residents who are admitted/readmitted with orders for [redacted] will have a corresponding individualized nursing plan of care initiated. The Director of Nursing and or Designee will audit new admissions and will ensure that patients with [redacted] will have a personalized care plan, weekly x4, then 2x a month for 3 months. How will the corrective action be monitored to ensure the deficient practice will not recur? The Director of Nursing and or Designee will report results of the Audit to the Quality Insurance Performance Improvement Committee x3 months. The QAPI meeting is attended by the NHA, DON, Medical Director, and Department Heads.	
F 689 SS=G	New Jersey Administrative Code: 8:39-11.2(e)1 Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		12/16/22

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F 689	Continued From page 10 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ155732 Based on interviews, record review, and facility policy review, the facility failed to ensure two-person assistance was provided with transfers in accordance with a resident's care planned needs, to prevent accidents/injuries for 1 (Resident #7) of 3 sampled residents reviewed for accidents. Specifically, Resident #7, who was care planned for [redacted] assistance with transfers, was transferred with the assistance of only one staff member on [redacted]2 and [redacted] Later the same day, Resident #7 was again transferred with only one staff member assisting, which resulted in Resident #7 sustaining a [redacted] to the [redacted] with exposure of [redacted] which required care in the hospital emergency room (ER). Findings included: Review of an "Admission Record" revealed the facility originally admitted Resident #7 on [redacted] and readmitted the resident on [redacted] with diagnoses which included [redacted] to [redacted] The Admission Record indicated the facility discharged the resident on [redacted] Review of the resident's medical record revealed an admission Minimum Data Set (MDS) assessment had not yet been completed as of	F 689	What corrective action will be accomplished for those residents affected by the deficient practice? Patient # 7 has been discharged from the facility. 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? 17 residents (who require at least [redacted] staff for transfers) were identified as having the potential to be affected by the deficient practice. Each of these resident's plan of care was reviewed and updated as needed to ensure that the appropriate minimum number of staff needed for transfers are reflected in the plan of care. 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 October 25, 2022, for RN/LPNs regarding access to information regarding resources required for patient transfers between surfaces. The re-education focused on the following:	

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(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 689	Continued From page 11 the date the resident was discharged. Review of a care plan, dated as initiated [redacted], revealed Resident #7 was at high risk for [redacted] and being [redacted] needs. The goal, which was dated as revised [redacted], was for the resident to be free of [redacted] through the next review date [redacted]. A planned intervention dated as initiated [redacted] indicated the resident was transferred with the assistance of [redacted] people and use of a [redacted]. Further review of Resident #7's care plan revealed a focus statement dated as initiated [redacted], which indicated the resident had the potential for [redacted] A planned intervention dated as initiated [redacted] was to use caution during transfers and bed mobility to prevent [redacted] and [redacted] against any [redacted]. Review of an incident report, dated [redacted] at 10:09 AM, revealed Nurse Manager (NM) #1 was called in to Resident #7's room by Certified Nursing Assistant (CNA) #6. NM #1 documented that he noticed Resident #7 was [redacted] from the [redacted] that was [redacted] while being transferred to a wheelchair. The report indicated that CNA #6 stated the resident's [redacted] the chair during the transfer. The nurse cleaned the [redacted], applied [redacted] used to hold a [redacted] and a [redacted], and notified the physician and the resident's family member. Review of an incident report, dated [redacted] at	F 689	a.Following a resident's plan of care as it relates to the number of staff required for transfers. b.Safe handling and transfers of resident's / patients with different weight bearing status. c.Information regarding transfers of residents and resources/equipment needed is available via 'Kardex" on the POC (Point of Care) for each resident. The Director of Nursing and/or Designee will audit patient transfers to ensure that nursing staff is compliant with the appropriate number of staff needed for patient transfers between surfaces. Audit will be through random observation by the Unit Manager and/or Designee of up to 5 residents weekly x4, then 2x a month for 3 months. How will the corrective action be monitored to ensure the deficient practice will not recur? The Director of Nursing and or Designee will report results of the Audit to the Quality Insurance Performance Improvement Committee x3 months. The QAPI meeting is attended by the NHA, DON, 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 _____	C 10/21/2022

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F 689	Continued From page 12 8:50 PM, revealed Licensed Practical Nurse (LPN) #5 was informed by CNA #6 that Resident #7's leg hit the side of the bed during a transfer. LPN #5 evaluated Resident #7 and found that the resident had [redacted] and [redacted] to the [redacted]. According to the incident report, Resident #7 was unable to give a description of the incident. The incident report indicated the immediate action taken was that LPN #5 informed Unit Manager (UM) #1, and UM #1 instructed LPN #5 to clean the [redacted], do a [redacted], and [redacted]. The report further indicated the physician and family member were notified, and the physician instructed LPN #5 to send Resident #7 to the hospital emergency department (ED) for evaluation. Review of a "Progress Note," dated [redacted] at 8:50 PM, revealed a nursing note that included a description of the [redacted] sustained by the resident during the [redacted]. The note indicated that the nursing supervisor observed the resident lying on the bed with an [redacted] and [redacted] that " [redacted]. The note revealed that [redacted] and [redacted] were noted to the [redacted]. The CNA reported that while [redacted] the resident to bed, the resident's [redacted] may have [redacted] of the [redacted] and resulted in the [redacted]. Review of a hospital "ED Provider Note," dated [redacted] revealed Resident #7 had a " [redacted] " to the [redacted] pplied. Additionally, a "significant [redacted] " was noted to the [redacted] of the [redacted] that	F 689		

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F 689	Continued From page 13	F 689		

was approximately 8 cm by 10 cm. The note indicated there were [redacted] with "some [redacted] and [redacted] was visible.

Review of an "Accident/Incident Report" revealed that on [redacted] CNA #6 demonstrated how she transferred Resident #7 from the chair to the bed. The report indicated LPN #4 and the US FOIA (b)(6)) were present during the demonstration. The report indicated the CNA demonstrated proper technique and that historically, the resident had been able to participate with transfers. In the area of the report titled, "Recommended steps to prevent recurrence" the report stated there was no deviation in care and it appeared the resident was suddenly unable to [redacted] and the staff was unable to prevent the resident's [redacted] the [redacted].

Review of a "Progress Note," dated [redacted] at 9:30 AM, revealed the Interdisciplinary Team (IDT) met to discuss Resident #7's "recent [redacted]" The note indicated the resident sustained a [redacted] during morning care [redacted] while being [redacted] from the [redacted] with an aide assisting and that the aide reported the resident's [redacted]. The note indicated the team discussed [redacted]; however, the resident weighed [redacted] and the [redacted] were not effective because they rolled down. The note indicated that later in the day, the resident was being [redacted] from the [redacted] but was being resistant at the time, and the resident's [redacted] the [redacted] during the [redacted], which was reported by the aide. The

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F 689	Continued From page 14 note indicated the resident NJ Ex Order 26.4b1 to the [redacted] that the physician thought should be evaluated at the ED. The note indicated the resident had a history of d[redacted] and was known to be resistant to care at times. Review of a care plan focus statement dated as initiated [redacted] revealed Resident #7's care plan was revised to indicate the resident was resistive to care at times related to [redacted] During an interview on 10/21/2022 at 3:41 PM, NM #1 indicated Resident #7 was being [redacted] by CNA #6 from the [redacted] and sustained a [redacted]. He stated that later in the day, the resident sustained a [redacted] and [redacted] during a [redacted] from the [redacted] to the [redacted] NM #1 reported that, according to CNA #6, Resident #7 was resisting the [redacted] when the resident [redacted]t their [redacted] of the [redacted]. He indicated CNA #6 was not assisted by another staff member during the [redacted]r of Resident #7 from the [redacted] to the bed. NM #1 revealed he was not aware that Resident #7 required [redacted] people for transfers. He stated on [redacted], he re-educated CNA #6 on proper transfer technique for Resident #7. NM #1 stated [redacted] were tried on Resident #7's [redacted] but they were rolling down the resident's [redacted]. He indicated Resident #7 was sent out to the ER for evaluation of the [redacted] and [redacted]. During an interview on 10/21/2022 at 3:56 PM, LPN #5 indicated it was reported to her by CNA #6 that the resident had a [redacted] on their [redacted] and was [redacted]. She stated she observed the [redacted] on the resident's [redacted] had been [redacted] on the [redacted], and that the [redacted]. She	F 689		

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F 689	Continued From page 15 indicated she cleaned the resident's [redacted] using [redacted] then the resident was sent out to the hospital. CNA #6 was not available for an interview during the complaint investigation. He was no longer employed at the facility. During an interview on 10/21/2022 at 4:10 PM, the[US FOIA (b)(6)]) stated the resident had incidents that resulted in [redacted] on [redacted] o separate occasions during t[redacted] conducted by CNA #6. He indicated CNA #6 was educated on proper transfer techniques after Resident #7's [redacted] and [redacted] incident. He reported that his expectation was for the residents at the facility to be [redacted] safely from their [redacted] to [redacted]. During an interview on 10/21/2022 at 4:05 PM, the[US FOIA (b)(6)] reported that Resident #7 sustained [redacted] during transfers, and she expected the staff to follow the plan of care when [redacted] a resident. She confirmed that Resident #7 required [redacted] persons for [redacted] Review of a facility policy titled, "Incident and Accident Report/Falls," dated 02/2021, revealed, "Procedure 1. Incidents or accidents include but are not limited to falls, injuries, medication errors, drug reaction, or any event which may result in trauma or inflicted bodily injury to a resident, guest, or employee. 2. Information recorded should include the resident's or individual's name, room number, date, and time of incident, extent of injury, treatment given- if any, and medical advice obtained, description of how the incident occurred, and names of any witnesses."	F 689		

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F 689	Continued From page 16 New Jersey Administrative Code: 8:39-27.1(a)	F 689		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 842		12/16/22

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F 842	Continued From page 17 purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ148986 Based on record review, interviews, and facility policy review, the facility failed to ensure licensed nursing staff consistently documented treatments in the medical record and/or documented an explanation if physician-ordered treatments were not completed for 1 (Resident #2) of 3 sampled	F 842	What corrective action will be accomplished for those residents affected by the deficient practice? Patient # 2 has been discharged from the facility. How will the facility identify other residents	

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F 842	Continued From page 18 residents reviewed for [redacted] care. Specifically, [redacted] that were ordered by the physician and scheduled on the "Medication Administration Record (MAR)" were not consistently signed/initialed as completed for Resident #2, and there was no documentation in the medical record as to whether the [redacted] were missed or why they were not initialed as completed. Findings included: Review of an "Admission Record" revealed Resident #2 had diagnoses which included [redacted] urther review revealed the resident was discharged on [redacted] Review of an admission Minimum Data Set (MDS), dated [redacted], revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating [redacted] The MDS indicated the resident required NJ Ex Order 26.4b1 with all activities of daily living (ADL) except eating. According to the MDS, the resident required [redacted]t [redacted] Review of an "Order Listing" in Resident #2's electronic medical record revealed a physician's order dated [redacted] for [redacted] to be performed [redacted] times daily, every [redacted] hours. Review of Resident #2's [redacted] Medication Administration Record (MAR) revealed the straight NJ Ex Order 26.4b1 were	F 842	having the potential to be affected by the same deficient practice and what corrective action will be taken? 7 residents were identified as having the potential to be affected by the deficient practice. These patients with [redacted] and or [redacted] ETAR's were audited for consistent documentation of treatment administration. 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 October 25, 2022, with RN/LPNs on accurate and timely documentation of the administration of treatment in the EMR (Electronic Medical Record) system. The Unit Managers and or Designee will audit current patients or any new patients with [redacted] and or [redacted] for consistent documentation of treatment administration weekly x4, then 2x per month for 3 months. How will the corrective action be monitored to ensure the deficient practice will not recur? The Director of Nursing and or Designee will report results of the Audit to the Quality Insurance Performance	

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F 842	Continued From page 19 scheduled for 12:00 AM (midnight), 6:00 AM, 12:00 PM (noon), and 6:00 PM, beginning on 09/18/2021 at midnight. There was no documentation to indicate the 6:00 PM [redacted] was completed on [redacted]; and no documentation the 12:00 PM [redacted] was completed on [redacted]. There was no documentation in the medical record to indicate the reason these [redacted] were not initialed by a licensed nurse as completed. During an interview on 10/21/2022 at 5:32 PM, the US FOIA (b)(6) stated she believed the resident received the [redacted] as ordered and that the dates/times that were skipped on the MAR were when an agency nurse worked. The US FOIA (b)(6) stated she had spoken to agency nurses about signing the MARs. The US FOIA (b)(6) indicated she expected all orders to be followed and signed off on the MAR as soon as they were completed. The surveyor was unable to contact the agency nurses who worked on the dates in question. Review of an undated facility policy titled, "Electronic Medical Record Orders, Ordering and Providers," revealed, "B. All medications and biological orders are entered, dated, and electronically signed by the person lawfully authorized to give such an order. The entering, verification, activation, and signing of orders in the EMR (Electronic Medical Record) is through an electronic signature which is unique for each authorized EMR user." New Jersey Administrative Code § 8:39-35.2(d)&(f)	F 842	Improvement Committee x3 months. The QAPI meeting is attended by the NHA, DON, Medical Director, and Department Heads.	

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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: Complaint Intake #NJ156866 Based on interviews, facility document review, and New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, it was determined that the facility failed to ensure staffing ratios were met. The facility was deficient in certified nursing assistant (CNA) staffing for residents on 28 of 28 day shifts and one of 21 evening shifts. This deficient practice had the potential to affect all residents. Findings included: 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 effective on 02/01/2021: One certified nurse aid 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	S 560	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? The Administrator provided re-education to the Director of Nursing and Staffing Coordinator on December 5, 2022, on the minimum staffing requirements by the Department of Health by shift. The Administrator, Director of Nursing and Staffing Coordinator will meet regularly to review staffing for the next day, staffing for the coming week, open positions, and recruitment efforts. The facility has implemented a	12/16/22

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

Electronically Signed | 12/09/22

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S 560	Continued From page 1 certified nurse aides, and each direct staff member shall be signed in to work as a certified nurse aide 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 Certified Nurse Aide (CNA) and perform certified nurse aide duties. 1. A review of the Nurse Staffing Reports, completed by the facility for the weeks of 07/31/2022 through 08/13/2022, revealed staff-to-resident ratios that did not meet the minimum requirements. The facility was deficient in CNA staffing for 14 of 14 day shifts and for one of 14 evening shifts as follows: - 07/31/2022 had 11 CNAs for 119 residents on the day shift, required 15 CNAs. - 08/01/2022 had 12 CNAs for 119 residents on the day shift, required 15. - 08/02/2022 had 10 CNAs for 118 residents on the day shift, required 15. - 08/03/2022 had 11 CNAs for 116 residents on the day shift, required 14. - 08/04/2022 had 11 CNAs for 116 residents on the day shift, required 14. - 08/05/2022 had 9 CNAs for 116 residents on the day shift, required 14. - 08/06/2022 had 12 CNAs for 116 residents on the day shift, required 14. - 08/07/2022 had 9 CNAs for 116 residents on the day shift, required 14. - 08/07/2022 had 11 CNAs for 116 residents on the evening shift, required 12. - 08/08/2022 had 8 CNAs for 120 residents on the day shift, required 14. - 08/09/2022 had 13 CNAs for 120 residents on	S 560	multifaceted approach to recruitment and retention including but not limited to, use of web-based recruitment advertising, contract utilization, sign on bonuses and referral bonuses. The company has onboarded a designated Workforce Management to assist with the above-mentioned recruitment efforts. The Staffing Coordinator will utilize the Recruitment Report to track and trend recruitment efforts weekly x4, then 2x a month for 3 months. How will the corrective action be monitored to ensure the deficient practice will not recur? The Administrator and or Designee will audit the Recruitment Report and provide information during the QAPI meeting x3 months. The QAPI meeting is attended by the Administrator, Director of Nursing, Medical Director, and Department Heads.	

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S 560	Continued From page 2	S 560		

the day shift, required 15.
- 08/10/2022 had 12 CNAs for 121 residents on the day shift, required 15.
- 08/11/2022 had 11 CNAs for 121 residents on the day shift, required 15.
- 08/12/2022 had 10 CNAs for 121 residents on the day shift, required 15.
- 08/13/2022 had 13 CNAs for 121 residents on the day shift, required 15.

2. Review of the Nurse Staffing Reports, completed by the facility for the weeks of 10/02/2022 through 10/15/2022, revealed staff-to-resident ratios that did not meet the minimum requirements. The facility was deficient in CNA staffing for 14 of 14 day shifts, as follows:

- 10/02/2022 had 11 CNAs for 135 residents on the day shift, required 17.
- 10/03/2022 had 12 CNAs for 135 residents on the day shift, required 17.
- 10/04/2022 had 11 CNAs for 133 residents on the day shift, required 17.
- 10/05/2022 had 10 CNAs for 133 residents on the day shift, required 17.
- 10/06/2022 had 13 CNAs for 133 residents on the day shift, required 17.
- 10/07/2022 had 14 CNAs for 133 residents on the day shift, required 17.
- 10/08/2022 had 14 CNAs for 133 residents on the day shift, required 17.
- 10/09/2022 had 11 CNAs for 133 residents on the day shift, required 17.
- 10/10/2022 had 11 CNAs for 137 residents on the day shift, required 17.
- 10/11/2022 had 13 CNAs 13 for 138 residents on the day shift, required 17.
- 10/12/2022 had 15 CNAs for 137 residents on the day shift, required 17.
- 10/13/2022 had 14 CNAs for 137 residents on

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 _____	C 10/21/2022

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 3	S 560		

the day shift, required 17.
- 10/14/2022 had 15 CNAs for 137 residents on the day shift, required 17.
- 10/15/2022 had 12 CNAs for 137 residents on the day shift, required 17.

During an interview on 10/21/2022 at 12:01 PM, the Director of Nursing (DON) stated it had been "a long uphill battle to keep staff." The DON indicated the facility was using agency staff and was able to give the staff scheduler the schedule a month in advance. He stated they used the same agency CNAs and nurses and that they were "pretty reliable." The DON indicated the facility had enough staff to help residents with their activities of daily living (ADL) care without the residents having long wait times.

During an interview on 10/21/2022 at 5:20 PM, the Administrator stated the facility had used a job/recruitment website, had participated in hiring fairs, and offered extra bonuses to try to acquire more permanent staff. The Administrator indicated the facility had plenty of agency workers available but wanted permanent staff and that this had proven to be a challenge. The Administrator stated the facility did have enough help, with the addition of agency staff, to provide competent and caring assistance to the residents.

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 _____	R-C 12/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite revisit conducted on 12/17/2022 determined the facility was in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care and the standards in the New Jersey Administrative Code 8:39, Standards for Licensure of Long-Term Care Facilities.	{F 000}		

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

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.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315068 Y1	A. Building B. Wing Y2	12/17/2022 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0609	Correction	ID Prefix F0656	Correction	ID Prefix F0689	Correction
Reg. # 483.12(c)(1)(4)	Completed	Reg. # 483.21(b)(1)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	12/16/2022	LSC	12/16/2022	LSC	12/16/2022
ID Prefix F0842	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/16/2022	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/21/2022	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060402 Y1	A. Building B. Wing Y2	12/17/2022 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	12/16/2022	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	
10/21/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO