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 01/30/2024

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 Complaint #: NJ00164865, NJ00165770, NJ00166293, NJ00167155, and NJ00170403 Survey Dates: 01/26/2024 and 01/30/2024 Census: 110 Sample Size: 5 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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 §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).	F 656		3/20/24

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

Electronically Signed | 03/10/2024

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 _____	C 01/30/2024

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 656	Continued From page 1 (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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: COMPLAINT #: NJ00167155 Based on interviews, medical record review, and review of other pertinent facility documents on 1/26/24 and 1/30/24, it was determined that the facility failed to initiate a comprehensive person center care plan for a resident with a [redacted]. The facility also failed to follow its undated policy titled "Nursing Documentation". This deficient practice was identified for 1 of 2 residents (Resident #4) reviewed for comprehesive Care Plan (CP) and was	F 656	CORRECTIVE ACTION: On 3/4/24, Resident #4 medical record was reviewed by the Director of Nursing (DON) for deficient practice. The resident□s [redacted] was resolved, and the care plan did not need to be updated. The resident did [redacted] from the deficient practice. IDENTIFICATION OF AT RISK RESIDENTS: All residents are potentially at risk for the deficient practice. This can be identified by reviewing 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 _____	C 01/30/2024

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 656	Continued From page 2 evidenced by the following: Review of the Medical Record was as follows: According to the "Face Sheet," Resident #4 was admitted to the facility with diagnoses that included but were not limited to: NJ Exec Order 26.4b1 [redacted] The surveyor reviewed the progress notes (PN) for Resident #4 which revealed: -A Physician PN, dated NJ Exec Order 26.4b at 3:22 P.M., Resident #4 was receiving treatment for: NJ Exec Order 26.4b1 [redacted] -A Physician PN, dated NJ Exec Order 26.4b at 9:10 P.M., Resident #4 was receiving treatment for: NJ Exec Order 26.4 [redacted] The surveyor reviewed the Order Summary Report for Resident #4 which revealed the following active Physician Orders (PO): -NJ Exec Order 26.4b1, related to NJ Exec Orde [redacted], Order date: NJ Exec Order 26.4b [redacted] Review of the Care Plan (CP) for Resident #4's failed to reveal a focus and interventions that address the resident's NJ Exec Order 26.4b1.	F 656	medical records. SYSTEMIC CHANGE: On 3/4/24 Assistant Director of nursing (ADON) initiated re-education for all interdisciplinary care plan team members responsible for writing care plans on the facility□s policy and procedure on documenting, developing, and updating comprehensive care plan The IDT will ensure that the care plans are completed in a timely manner, reviewed, and updated as necessary. All In services will be completed on 3/19/24. QUALITY ASSURANCE: Care plans will be reviewed weekly in accordance with the care plan review schedule by the ITD/designee. All care plans will be updated as indicated. The Director of Nursing (DON), / designee will complete random weekly audits of residents care plans for 8 weeks, then bi-weekly x 4 weeks, and then monthly x 3 All findings of concern will be immediately addressed and reported to the Administrator as well as the Quality Assurance (QA)/QAPI committee quarterly for six months or until compliance is met.	

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 01/30/2024

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 656	Continued From page 3	F 656		

On 01/30/24 at 12:30 P.M., the surveyor interviewed Licensed Practical Nurse (LPN) #2, who said that the U.S. FOIA (b) (6) is responsible for updating and initiating CPs. LPN #2 further stated that it is important that the CP be kept up to date so that the needs of the resident could be met.

On 01/30/24 at 12:40 P.M., the surveyor interviewed the Unit Manager/LPN (UM/LPN) #2, who said that the U.S. FOIA (b) (6) or the U.S. FOIA (b) (6)), are responsible for updating CPs. He further explained that the, "CPs were usually updated during care conferences, or if new issues develop." UM/LPN #2 added that CPs were important because it was the plan of care for the resident. The UM/LPN #2 further stated that the CP should be updated to reflect the NJ Exec Order 26.4 as soon as a treatment is ordered.

On 01/30/24 at 01:30 P.M., the surveyor interviewed the U.S. FOIA who said that the CP was the individualized plan of care for each resident and that, "All NJ Exec Order 26.4b1 a resident's NJ Exec Order status are to be reflected there." The U.S. FOIA further explained that any member of the interdisciplinary team could update the CP. The surveyor asked the U.S. FOIA if a resident develops an NJ Exec Order 26.4 that requires treatment, would that be reflected on the CP? The U.S. FOIA stated, "Yes, anything new should be reflected on the CP." The U.S. FOIA reviewed Resident #4s CP in the presence of the surveyor. The surveyor asked if Resident #4's CP addressed NJ Exec Order 26.4b1, at which time the U.S. FOIA requested for an opportunity to search the CP's "history" as there

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 01/30/2024

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 656	Continued From page 4 may not be a current diagnosis. The [U.S. FOIA] did not provide the surveyor with any additional documentation regarding Resident #4's CP. A review of the facility's undated "Policy/Procedure Nursing Documentation" policy revealed that documentation was to be accurately maintained at all times. NJAC: 8:39-11.1 NJAC: 8:39-11.2(i)	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: COMPLAINT #: NJ00170403 Based on interviews, medical record review, and review of other pertinent facility documents on 1/26/24 and 1/30/24, it was determined that the facility staff failed to consistently document in the "Documentation Survey Report" (DSR) the Activities of Daily Living (ADL) status and care provided to the resident according to facility policy and protocol for 2 of 2 residents (Resident #4 and Resident #5) reviewed for documentation. This deficient practice was evidenced by the following:	F 677	CORRECTIVE ACTION: Resident #4 medical records were reviewed for deficient practice. Resident #5 is no longer in the facility. Resident #4 is receiving all Activities of Daily Living (ADL) and are documented in the Point of Care (POC). Residents #4 did [NJ Exec Order 26.4b1] from the deficient practice. On 1/30/24, an audit was completed by the Director of Nursing, supervisors and unit managers on all residents on ADLs to ensure that documentation is completed by certified nursing assistants on each shift to prevent further repeat deficient practice.	3/20/24

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 01/30/2024

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 677	Continued From page 5 1.) According to the Admission Record (AR), Resident #4 was admitted to the facility with diagnoses that included but were not limited to: NJ Exec Order 26.4b1 [redacted] The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b, indicated that Resident #4 had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, which indicated that the resident's NJ Exec Order 26.4b1. The MDS also indicated that the resident needed assistance with ADLs including NJ Exec Order 26.4b1 [redacted] A review of the Resident #4's Care Plan (CP) noted that the resident required extensive assistance with NJ Exec Order 26.4b1 [redacted] Review of Resident #4's DSR (ADL Record) and the progress notes (PN) for NJ Exec Order 2 thru NJ Exec Order 2, lack any documentation to indicate that the care for NJ Exec Order 26.4b1 [redacted] and NJ Exec Order 26.4b was provided and/or the resident NJ Exec Order 2b care on the following dates and shifts: 7:00 am-3:00 pm shift on NJ Exec Order 26.4b1 [redacted]. 3:00 pm-11:00 pm shift on NJ Exec Order 26.4b1 [redacted]	F 677	IDENTIFICATION OF AT RISK RESIDENTS: All residents residing in the facility may be potentially at risk for the deficient practice. This can be identified by reviewing the residents activities of daily living records/Medical records. SYSTEMIC CHANGE: On 3/4/24, re-education began by the Assistant Director of Nursing for all nursing staff to review the ADL documentation policy and the importance of documenting in a timely manner. In-service will be completed on 3/19/24. Audits will be conducted on every shift by unit managers and shift supervisors to ensure completion of documentation. The facility has and shall continue to educate staff on the need to document ADLs as it pertains to facility policy. All new hires will be educated upon date of hire of the facility policy of ADL documentation to include completion and accuracy. Agency staff will be educated on ADL documentation policy prior to the start date. QUALITY ASSURANCE: The Director of Nursing (DON), / designee will complete random weekly audits of the ADL documentation for accuracy and timely completion for 8 weeks, then bi-weekly x 4 weeks, and then monthly x 3 All findings of concern will be immediately addressed and reported to the Administrator as well as the Quality Assurance (QA)/QAPI committee quarterly for six months or until compliance is met.	

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 01/30/2024

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 677	Continued From page 6	F 677		

11:00 pm-7:00 am shift on NJ Exec Order 26.4b1 [redacted]

2.) According to the AR, Resident #5 was admitted to the facility with diagnoses that included but were not limited to: NJ Exec Order 26.4b1 [redacted].

The Quarterly MDS, dated NJ Exec Order 26.4b, revealed that Resident #5 had a BIMS of [redacted] out of 15 which indicated that the resident's NJ Exec Order 26.4b1 [redacted] The MDS also indicated that the resident needed NJ Exec Order 26.4b1 assistance with NJ Exec Order 26.4 [redacted] and NJ Exec Order 26.4b1 [redacted] and NJ Exec Order 26.4b [redacted].

A review of the Resident #5's CP noted that the resident required extensive assistance with NJ Exec O [redacted].

Review of Resident #5's DSR and the PN for NJ Exec Order 26.4b1 [redacted] NJ Exec Order 2 [redacted], lacked any documentation to indicate that the care for NJ Exec Order 26.4b1 [redacted] and NJ Exec Order 26.4 [redacted] was provided and/or the resident NJ Exec Order 2 [redacted] care on the following dates and shifts;

-7:00 am-3:00 pm shift on NJ Exec Order 26.4b1
-3:00 pm-11:00 pm shift on NJ Exec Order 26.4b1 [redacted]
-11:00 pm-7:00 am shift on NJ Exec Order 2 [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 _____	C 01/30/2024

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 677	Continued From page 7	F 677		

Review of Resident #5's DSR and the PN for [redacted] thru [redacted] lack any documentation to indicate that the care for [redacted] was provided and/or that the resident [redacted] care on the following dates and shifts;

-7:00 am-3:00 pm shift on [redacted] and [redacted].
-3:00 pm-11:00 pm shift on [redacted], and [redacted] thru [redacted].
-11:00 pm-7:00 am shift on [redacted]

On 01/26/24 at 10:49 A.M., the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) #1 who said it was important to document ADL care so that the care team was aware that care was provided to the resident and at what level of assistance the resident required. UM/LPN #1 explained that Certified Nurse Aides (CNA) were responsible for providing ADL care and documenting the care provided in the electronic system. UM/LPN #1 said that it is expected that all care be documented at least twice a shift and that there should be no missing documentation on the ADL reports [DSR].

On 1/30/24 at 11:40 A.M., the surveyor interviewed CNA #2 who said that CNAs were responsible for documenting ADLs. She further stated that all documentation is entered into the electronic system, and that it is to be done at least twice a shift. CNA #2 said, "If there are blanks, it means that the CNA did not document the care that was done." CNA #2 further stated that, "There should be no blanks and that documentation is important to show all of the care that the residents received."

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 01/30/2024

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 677	Continued From page 8 On 01/30/24 at 11:50 A.M., the surveyor interviewed LPN #1, who said that CNAs were responsible for completing all ADL care. LPN #1 also said that the CNAs documented all care in the electronic system. LPN #1 further said that there should be no blanks in the system, "Blanks mean that the task wasn't completed." On 01/30/24 at 01:30 P.M., the surveyor interviewed the U.S. FOIA (b) (6)) who stated that the CNAs were responsible for providing ADL care and documenting in the electronic system throughout the shift. He further explained that it was the responsibility of the nurse supervisor to ensure that the CNAs completed and documented the completion of the tasks. The U.S. FOIA (said, "There should not be any [missing documentation] blanks. That it could mean that it wasn't done, or it could also mean that the CNA forgot. There is no way for me to know which one, but the expectation is that all care is documented and there should be no blanks." Review of the facility's "Activities of Daily Living (ADLs)" policy, revised October 2023, reflected "A resident who is unable to carry out ADLs will receive the necessary services ..." The policy further noted that, "All ADLs will be documented at a minimum daily in resident record." NJAC 8:39-35.2(d)(9)	F 677		
F 770 SS=D	Laboratory Services	F 770		3/20/24

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 01/30/2024

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 770	Continued From page 9 CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: COMPLAINT #: NJ00166293 Based on observation, interview, record review, and other facility documentation on 1/26/24 and 1/30/24, it was determined that the facility failed to NJ Exec Order 26.4b1 in a timely manner. This deficient practice was identified for 1 of 1 resident (Resident #4)reviewed for NJ Exec Order 26.4b1 services and was evidenced by the following: The surveyor reviewed the medical record for Resident #4. According to the Admission Record, Resident #4 was admitted to the facility with diagnoses that included but were not limited to NJ Exec Order 26.4b1 [redacted] The Quarterly Minimum Data Set (MDS), an	F 770	Corrective Action: Resident #4 medical record reviewed by the Director of Nursing (DON) for deficient practice. The resident did NJ Exec Order 26.4b1 from the deficient practice. On 1/30/24, the Director of Nursing conducted an audit on lab orders for the month of January for completion. No issues found from the audit. IDENTIFICATION OF AT RISK RESIDENTS: All residents are potentially at risk for the deficient practice. This can be identified by reviewing the medical records and physician orders. SYSTEMIC CHANGE: The Director of Nursing or designee will re-educate licensed nurses on laboratory services per the facility policy and procedure to include: processing orders, obtaining lab specimens, and notification to MD if unable to obtain lab . Education for licensed nurses will be completed on 3/19/24	

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 01/30/2024

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 770	Continued From page 10 assessment tool used to facilitate the management of care, dated [NJ Exec Order 26.4b] indicated that Resident #4 had a Brief Interview for Mental Status (BIMS) score of [NJ E] out of 15, which indicated that the resident's [NJ Exec Order 26.4b1]. The surveyor reviewed Resident #4's Order Summary Report (OSR) for the active orders as of [NJ Exec Order 26.4b], which reflected that a [NJ Exec Order 26.4b1] was ordered on [NJ Exec Order 26.4b]. The surveyor reviewed the Resident #4's Progress Notes (PN) for August 2023 which revealed that on [NJ Exec Order 26.4b] at 6:09 P.M. a [NJ Exec Orde] was collected and placed in [NJ Exec Orde] [at 6:00 A.M.]," by the Unit Manager/Licensed Practical Nurse (UM/LPN) #1. The PN did not reveal any further documentation regarding when the [NJ Ex] picked up Resident #4's [NJ Exec Order 26.4b1]. The surveyor reviewed a [NJ Exec Order 26.4b1] Report that was provided by the facility which reflected the following: -Collection Date [NJ Exec Order 26.4b] 12:00 P.M. -Received Date [NJ Exec Order 26.4b] 12:51 P.M. -Reported Date: [NJ Exec Order 26.4b] 1:25 P.M. On 01/26/24 at 2:50 P.M., the surveyor interviewed the UM/LPN #1, who stated that after a doctor puts in an order for a [NJ Exec Order 26.4b1] it was the responsibility of the nurse to obtain the [NJ Exec Order 2] as soon as possible. He further explained that, "Once the [NJ Exec Order 2] is obtained, it is placed in the [NJ Exec Orde] for the next pick-up day. Pick-up days	F 770	QUTERTLY ASSURANCE: The Director of Nursing Services (DON) or designee will monitor Laboratory services to ensure Laboratory specimens are obtain and the physicians are notified with results in a timely manner. The DON or designee will do a random audit ten (10) records per week for one (1) month then five (5) records every two (2) weeks for two (2) months, then five (5) randomly monthly. Discrepancies will be promptly reported to the Director of Nursing and Administrator. This plan of correction will be monitored at the Quality Assurance/QAPI Committee for four (4) quarters or until such a time consistent substantial compliance has been met.	

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 01/30/2024

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 770	Continued From page 11	F 770		

are Tuesdays and Fridays." When the surveyor asked UM/LPN #1 why Resident #4's [NJ Exec Order 26.4b1] was not received by the lab until [NJ Exec Order 26.4b]? UM/LPN #1 stated that he could not recall when the [NJ Exec Order 26.4b1] was picked up but that it should have been on the next scheduled day.

On 01/26/24 at 3:00 P.M., the surveyor interviewed the [U.S. FOIA (b) (6)]) who stated that, "Once collected, the [NJ Exec Order 26.4b1] are [would] placed in the designated [NJ Exec Orde] and staff contact the [NJ Exe] to schedule pick-up on the next scheduled day."

During a follow-up telephone interview, on 02/08/24 at 3:24 P.M., the [U.S. FOIA] said that the facility's scheduled [NJ Exe] pick-up days were Tuesdays & Fridays. The surveyor asked why Resident #4s [NJ Exec Order 26.4b1] was not picked up until [NJ Exec Order 26.4b]. The [U.S. FOIA] said that "ideally" it should have been picked up on [NJ Exec Order 26.4b]. No additional information was provided to the surveyor.

During a telephone interview with the surveyor, on 02/09/2024 at 12:21 P.M., the physician said that the facility had a contract with a [NJ Exec Order 26.4b1] to pick up on Tuesdays and Fridays. The physician further stated, "Unless a [NJ Exe] was ordered as 'stat', the expectation was that it would be picked on the next Tuesday or Friday, whichever was first." The physician said that this included [NJ Exec Order 26.4b1]. The physician said although she recalled working with Resident #4, she could not recall the details of the event. The surveyor asked if it was reasonable for a [NJ Exec Order 26.4b1] that 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 _____	C 01/30/2024

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 770	Continued From page 12 collected on [NJ Exec Order 26.4b] take[NJ Exec] [NJ Exec O] to get to the lab [NJ Exec Order 26.4b1] and the physician said, "I am unsure as to why it took [NJ Exec Order 26], but it should have been sooner." The physician further stated, "I would have expected that the [NJ Exec Order 26.4b2] should have been picked up on the next scheduled day [NJ Exec Order 26.4b1]." Review of the facility's "Laboratory Services and Reporting" policy, revised October 2023, indicated, "The facility must provide or obtain services when ordered by a physician ..." The policy also indicated that the laboratory services are to meet the needs of its residents and that, " ...The facility is responsible for the appropriateness of the laboratory services ..."	F 770		
F 842 SS=D	N.J.A.C. 8:39-11.2(b) 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	F 842		3/20/24

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 01/30/2024

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 842	Continued From page 13	F 842		

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 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-

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 01/30/2024

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 842	Continued From page 14 (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 #: NJ00165770 Based on observation, interview, record review, and review of other pertinent facility documentation on 01/26/24 and 01/30/24, it was determined that the facility failed to provide [redacted] care to a resident that was dependent on staff for activities of daily living (ADLs). This deficient practice was identified for 1 of 2 residents (Resident #4) reviewed for [redacted] and was evidenced by the following: The surveyor reviewed the medical record for Resident #4. According to the Admission Record, Resident #4 was admitted to the facility with diagnoses that included but were not limited to [redacted]	F 842	CORRECTIVE ACTION: Resident #4 medical records were reviewed for deficient practice. Resident #4 is receiving her [redacted] per her plan of care and documented in the Point of Care (POC) and Treatment administration Record. Residents #4 did not have [redacted] from the deficient practice. On 1/30/24, an audit was completed by the Director of Nursing, supervisors, and unit managers on all residents to ensure showers are provided and documentation is completed by certified nursing assistants on each shift to ensure other residents are not affected by the deficient practice. IDENTIFICATION OF AT RISK RESIDENTS: The facility has determined that all residents Dependent on Activities of Daily Living are potentially at risk for the deficient practice. This can be identified by reviewing the medical records. SYSTEMIC CHANGE: On 3/4/24, re-education began by the Assistant	

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 01/30/2024

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 842	Continued From page 15 The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [NJ Exec Order 26.4b] revealed that Resident #4 had a Brief Interview for Mental Status (BIMS) score of [NJ Ex] out of 15, which indicated that the resident's NJ Exec Order 26.4b1. The MDS also indicated that the resident required substantial assistance with [NJ Exec Order 26.4b1] Review of Resident #4's Care Plan (CP) revealed a "Focus," initiated on [NJ Exec Order 26.4b] that Resident #4 had an ADL NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1. The CP indicated that the resident required extensive assistance with [NJ Exec Order 26] On 01/26/24 at 10:38 A.M., the surveyor observed Resident #4 sitting up in bed, wearing a hospital gown. The resident's NJ Ex Order 26.4(b)(1), and the gown and bedding were clean. Resident #4 said that he/she had just returned to the room after receiving a [NJ Exec Order 26] Resident further stated that, "I'm receiving my [NJ Exec Order 26.4] as scheduled now, but I was not getting them back in [NJ Exec O] The surveyor reviewed the resident's Documentation Survey Report v2 (DSR) for [NJ Exec O] and noted that there was no documentation noted for "[NJ Exec Order 26.4] on [NJ Exec Order 26.4b1] on the 7:00 A.M. to 3:00 P.M. shift. Review of Resident #4's Progress Notes for [NJ Exec O] revealed no documentation regarding [NJ Exec Order 26.4b1] on [NJ Exec Order 26.4b1].	F 842	Director of Nursing for all nursing staff, reviewed the ADL care documentation policy and the importance of documenting in a timely manner. In-service will be completed on 3/19/24. The facility has implemented a system to have shower days documented on the treatment administration record to ensure the primary nurses document when showers are provided or refused. Audits will be conducted on every shift by unit managers and shift supervisors to ensure completion of documentation. The facility has and shall continue to educate staff on the need to document ADLs as it pertains to facility policy. All new hires will be educated upon date of hire of the facility policy of ADL documentation to include completion and accuracy. Agency staff will be educated on ADL documentation policy prior to the start date. QUALITY ASSURANCE: The Unit Mangers will monitor on their respective units to ensure that showers are provided and documented for accuracy and timely completion daily on all shifts for twelve weeks, then twice daily for eight weeks and once daily for four weeks. Any findings from the audit will be addressed immediately and will be reported to the Director of Nursing and the Administrator as well as to the QA/QAPI committee quarterly for six months or until compliance is met.	

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 01/30/2024

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 842	Continued From page 16	F 842		

On 01/26/24 at 10:49 A.M., the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) #1 who stated it was important to document ADL care so that the care team was aware that care was provided to the resident and at what level of assistance the resident required. UM/LPN #1 explained that Certified Nurse Aides (CNA) were responsible for providing ADL care and documenting the care provided in the electronic system. UM/LPN #1 stated that [redacted] were scheduled twice a week and were usually assigned based on room and bed numbers. He added that accommodations were also made based on residents' preferences. UM/LPN #1 further stated that it is expected that all care be documented at least twice a shift and that there should be no missing documentation on the ADL reports [DSR].

On 01/30/24 at 11:50 A.M., the surveyor interviewed LPN #1, who said that CNAs were responsible for completing all ADL care. LPN #1 added that the CNAs documented all care in the electronic system. She stated that it was important to document ADL care because it reflected that the care was provided and at what level of assistance the resident received. LPN #1 further stated that there should be no blanks in the system and that, "Blanks mean that the task wasn't completed."

On 01/30/24 at 01:30 P.M., the surveyor interviewed the [redacted]) who stated that ADL documentation reflected how much a resident can participate in their own care.

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 01/30/2024

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 842	Continued From page 17	F 842		

He said that the CNAs were responsible for providing ADL care and documenting in the electronic system throughout the shift. He further explained that it was the responsibility of the nurse supervisor to ensure that the CNAs completed and documented the completion of the tasks. The U.S. FOIA said, "There should not be any [missing documentation] blanks. That it could mean that it wasn't done, or it could also mean that the CNA forgot. There is no way for me to know which one, but the expectation is that all care is documented and there should be no blanks."

During a telephone interview on 02/06/24 at 03:25 P.M., CNA #1 said that CNAs were responsible for ADL care and that everything was documented in the electronic system. She further stated that NJ Exec Order 26.4b1 were provided twice weekly. She explained that if a resident were to refuse, the CNA was to try again later, in addition to notifying the nurse and documenting. CNA #1 said, "I try to document at least twice a shift, around lunch time and before the end of the day. There are times, rarely, when I forget but I try to do it right then and there because if it wasn't documented it wasn't done." She further explained, "[Resident #4] NJ Exec Order 26.4b1 if I'm there. I must have forgotten."

Review of the facility policy, "Activities of Daily Living," with a last revised date of October 2023, indicated that "All ADLs will be documented at a minimum daily in resident record."

NJAC 8:39-27.1(c), 27.2(i)

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 01/30/2024

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

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 01/30/2024

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 Complaint #: NJ00164865, NJ00165770, NJ00170403 The facility was not in compliance with the standards in the New Jersey Administrative code, 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: Complaint #: NJ00164865, NJ00165770, NJ00170403 Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 19 of 42 day shifts. The deficient practice was evidenced by the following: Reference: New Jersey Department of Health	S 560	CORRECTIVE ACTION: Efforts to hire facility staff will continue until there is adequate staff to serve all residents. Until that time, the facility will utilize staffing agencies to fill any open spots in the schedule. IDENTIFICATION OF THE RESIDENTS AT RISK: All residents have the potential to be at risk for the deficient practice. SYSTEMIC CHANGE: The facility Administrator has Contracted with	3/20/24

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

Electronically Signed | 03/10/24

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 01/30/2024

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 (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 as 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 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 of all staff members shall be CNAs and each direct staff member shall be signed into 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 CNA and perform CNA duties. The surveyor requested staffing for the weeks of 06/04/2023 to 06/10/2023, 07/09/2023 to 07/15/2023, 07/30/2023 to 08/05/2023, 08/27/23 to 09/02/2023, and 01/07/2024 to 01/20/2024. The facility was deficient in CNA staffing for resident on 19 of 42 day shifts as follows: -06/04/23 had 14 CNAs for 122 residents on the day shift, required at least 15 CNAs. -07/10/23 had 13 CNAs for 113 residents on the day shift, required at least 14 CNAs. -07/15/23 had 13 CNAs for 114 residents on the day shift, required at least 14 CNAs. -08/02/23 had 13 CNAs for 114 residents on the day shift, required at least 14 CNAs.	S 560	additional staffing agencies to secured supplemental facility staffing. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to become more competitive in the marketplace. In addition, the director of nursing will meet daily with the staffing coordinator to ensure appropriate staffing. QUALITY ASSURANCE: The Director of Nursing or designee will review staffing schedules daily to ensure adequate staffing for all shifts. Findings from the review will be reported to the Administrator. Any issue from the findings will be addressed immediately. The results of the staffing review will be submitted to the QA/QAPI Committee quarterly for 6 months or until compliance is met.	

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 01/30/2024

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 -08/27/23 had 9 CNAs for 116 residents on the day shift, required at least 14 CNAs. -08/31/23 had 13 CNAs for 118 residents on the day shift, required at least 15 CNAs. -09/01/23 had 14 CNAs for 117 residents on the day shift, required at least 15 CNAs. -01/07/24 had 12 CNAs for 122 residents on the day shift, required at least 15 CNAs. -01/08/24 had 14 CNAs for 121 residents on the day shift, required at least 15 CNAs. -01/09/24 had 14 CNAs for 121 residents on the day shift, required at least 15 CNAs. -01/10/24 had 13 CNAs for 121 residents on the day shift, required at least 15 CNAs. -01/11/24 had 14 CNAs for 121 residents on the day shift, required at least 15 CNAs. -01/12/24 had 14 CNAs for 120 residents on the day shift, required at least 15 CNAs. -01/13/24 had 13 CNAs for 118 residents on the day shift, required at least 15 CNAs. -01/15/24 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs. -01/17/24 had 14 CNAs for 117 residents on the day shift, required at least 15 CNAs. -01/18/24 had 14 CNAs for 117 residents on the day shift, required at least 15 CNAs. -01/19/24 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs. -01/20/24 had 14 CNAs for 117 residents on the day shift, required at least 15 CNAs.	S 560		

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	3/21/2024 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	F0656	Correction	ID Prefix	F0677	Correction	ID Prefix	F0770	Correction
Reg. #	483.21(b)(1)(3)	Completed	Reg. #	483.24(a)(2)	Completed	Reg. #	483.50(a)(1)(i)	Completed
LSC		03/21/2024	LSC		03/21/2024	LSC		03/21/2024
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		03/21/2024	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?
1/30/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060402 Y1	A. Building B. Wing Y2	3/21/2024 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	03/21/2024	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	
1/30/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO