

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

PRINTED: 07/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2024
NAME OF PROVIDER OR SUPPLIER ABIGAIL HOUSE FOR NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1105 -1115 LINDEN STREET CAMDEN, NJ 08102		
(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	<p>INITIAL COMMENTS</p> <p>A Complaint Survey was conducted on behalf of the New Jersey Department of Health.</p> <p>Complaint #: NJ00157459, NJ00159311, NJ00161356, NJ00169797, NJ00166647, and NJ00169803</p> <p>Survey Dates: 02/05/24 - 02/07/24</p> <p>Survey Census: 170 Sample Size: 11 Supplemental Residents: 0</p> <p>THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/29/2024

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.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060418	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/07/2024
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NAME OF PROVIDER OR SUPPLIER ABIGAIL HOUSE FOR NURSING & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1105 -1115 LINDEN STREET CAMDEN, NJ 08102
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S 000	Initial Comments Complaint #: NJ00157459, NJ00159311, NJ00161356, NJ00169797, NJ00166647, and NJ00169803 Survey Dates: 02/05/24 - 02/07/24 Survey Census: 170 Sample Size: 11 Supplemental Residents: 0	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on 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 4 of 14 day shifts as follows: This deficient practice had the potential to affect all residents. Findings include: 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 as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were	S 560	1. All residents have the potential to be affected by a staff shortage. However no care issues were identified on the four shifts that were found deficient. The Staffing Coordinator was in-serviced regarding the tag S560 to ensure that the staffing requirements are met. 2. All residents are at risk to be affected by the deficient practice. 3. Sign on and referral bonuses are in place along with overtime and weekend bonuses to ensure the facility is staffed appropriately. The facility also uses external resources to increase recruitment of direct staff and to ensure the availability of other staffing resources (e.g. contracted staff) in the event of a staffing shortage.	2/22/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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02/29/24

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060418	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/07/2024
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NAME OF PROVIDER OR SUPPLIER ABIGAIL HOUSE FOR NURSING & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1105 -1115 LINDEN STREET CAMDEN, NJ 08102
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S 560	<p>Continued From page 1</p> <p>effective on 02/01/2021:</p> <p>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.</p> <p>As per the "Nurse Staffing Report" completed by the facility for the 2 weeks of staffing from 01/21/2024 to 02/3/2024, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below:</p> <p>1. For the 2 weeks of staffing from 01/21/2024 to 02/03/2024, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows:</p> <p>-01/21/24 had 16 CNAs for 169 residents on the day shift, required at least 21 CNAs. -01/27/24 had 17 CNAs for 167 residents on the day shift, required at least 21 CNAs. -01/28/24 had 17 CNAs for 169 residents on the day shift, required at least 21 CNAs. -02/03/24 had 20 CNAs for 171 residents on the day shift, required at least 21 CNAs.</p>	S 560	<p>The Facility has just recently contracted with a large national company for additional help with staffing.</p> <p>For the next month, the Administrator/designee will review the projected staffing hours daily to ensure staffing hours are above state minimum.</p> <p>4. Findings will be submitted for 3 months to the monthly QAPI committee who will determine further inventions as needed.</p>	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 060418	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 4/3/2024
NAME OF FACILITY ABIGAIL HOUSE FOR NURSING & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1105 -1115 LINDEN STREET CAMDEN, NJ 08102	

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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 2/7/2024
 CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
 YES NO