STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315267	A. BUILDING _____ B. WING _____	11/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABIGAIL HOUSE FOR NURSING & REHABILITATION LLC	1105 -1115 LINDEN STREET CAMDEN, NJ 08102

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F 000	INITIAL COMMENTS STANDARD SURVEY CENSUS: 168 SAMPLE SIZE: 26 plus 2	F 000		
F 274 SS=D	COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE CFR(s): 483.20(b)(2)(ii) (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to a) conduct a Significant Change in Status Assessment (SCSA) Resident Assessment Instrument (RAI) for a resident that had an overall deterioration in condition, (Resident #8) and b) conduct a Significant Change in Status Assessment RAI on a resident who elected Exec Order 26 § 4b1 individual's heal, (Resident #22). This deficient practice was identified for 2 of 26 residents whose medical records were reviewed and was evidenced by the following:	F 274	1. Residents #8, and #22 were identified to have a Significant Change in Status. A Significant Change in Status Assessment (SCSA) and a resident Assessment Instrument (RAI) has been completed and transmitted for both residents. 2. Any residents that have a significant change in their physical or mental condition can be affected by the facility not having a Significant Change in Status Assessment done.	11/17/17

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/23/2017

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 274	Continued From page 1 1) During the initial tour of the facility on 10/3/17 at 9:40 a.m. the Unit Manager (UM) stated that Resident #8 had diagnoses that included Exec Order 26 § 4b1 individual's health info. The UM stated the resident had Exec Order 26 § 4b1 individual's health info The surveyor observed the resident in bed with both eyes closed. The surveyor reviewed a RAI dated Exec Order 26 which revealed that the resident was able to eat by mouth with supervision and cueing from staff. This RAI also indicated that Resident #8 had no skin breakdown. According to the Nursing Admission Evaluation dated Exec Order 26 § 4, the resident returned from the hospital with a Exec Order 26 § 4b1 individual's health info The surveyor reviewed all of the completed RAIs for the resident in the presence of the UM and observed there was no Significant Change RAI completed for the resident following the Exec Order 26 § readmission with significant changes in condition. The UM confirmed and agreed that a Significant Change RAI should have been completed. 2) On 11/2/17 at 9:00 a.m., the surveyor reviewed the physician's orders sheet and observed a 9/13/17 physician's order for a Exec Order 26 § 4b referral. The surveyor reviewed the "Evaluation for Services" form and observed that	F 274	3. The MDS coordinator and all the Unit Managers were in serviced on Nov. 17th 2017 how to determine if there has been a significant change in a residents physical or mental condition as well as instituting a Significant Change in Status Assessment. 4. There will be a weekly meeting between the MDS coordinator and all the Unit Managers to discuss any residents that have been identified with a Significant Change in their physical or mental condition. Additionally, the MDS coordinator will be reporting all residents who have had a Significant Change in Status to the QA committee on a quarterly basis for 1 year.	

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F 274	Continued From page 2 the date of Exec Order 26 § 4b election was 9/18/17. The surveyor reviewed all the completed MDSs for the resident in the presence of the UM, which revealed that there was no Significant Change RAI completed for the resident within 14 days from the resident's hospice election as required. The UM confirmed and agreed that a Significant Change RAI should have been completed. On 11/3/17 the surveyor reviewed the facility's Policy on "Resident Assessment, MDS, Triggers, and CAA's" which was provided by the Director of Nursing. This policy indicated that "Residents will be reassessed at the time it is determined there is a significant, permanent change in a resident's condition. Such change requires the RAI (Resident Assessment Instrument) process be completed as soon as possible but no later than the fourteenth (14th) day after this determination." NJAC 8:39-11.2(i),(g)	F 274		
F 278 SS=E	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed.	F 278		12/7/17

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F 278	Continued From page 3 (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and review of the medical record and review of other facility documentation, it was determined that the facility failed to ensure that a Registered Nurse (RN) signed and certified the completion of the Minimum Data Set (MDS), an assessment tool, for 15 of 26 residents reviewed (Residents #5, #6, #7, #8, #9, #10, #11, #12, #14, #16, #22, #23, #24, #25 and #26). This deficient practice was evidenced by the following: 1) On 11/2/17 at 10:00 a.m. the surveyor reviewed the MDS of Resident #24. The 10/8/17 Discharge assessment-return not anticipated MDS was signed by a Licensed Practical Nurse (LPN) in section Z0500.	F 278	1. Residents #5,6,7,8,9,10,11,12,14,16,22,23,24,25,26 will have their MDS assessment resubmitted with a Registered Nurse signing and certifying its completion. 2. All the residents in the facility need to have their MDS assessment signed and certified by a Registered Nurse. 3. The Unit Managers and MDS assistant were all in-serviced on Nov. 17th 2017 for the need of the MDS coordinator/ RN designee to sign and certify the completion of all MDS assessments.	

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F 278	Continued From page 4 2) On 11/2/17 at 10:25 a.m. the surveyor reviewed the MDS of Resident #25. The Exec Order 26 § 4 Discharge assessment-return not anticipated MDS was signed by a LPN in section Z0500. 3) On 11/2/17 at 10:50 a.m. the surveyor reviewed the MDS of Resident #26. The Exec Order 26 § 4 Discharge assessment-return not anticipated MDS was signed by a LPN in section Z0500. 4) On 10/31/17 the surveyor reviewed the MDS of Resident #5. The Exec Order 26 § 4 Quarterly MDS was signed by a LPN in section Z0500. 5) On 11/1/17 the surveyor reviewed the MDS of Resident #6. The Exec Order 26 Quarterly MDS was signed by a LPN in section Z0500. The Exec Order 26 § Annual MDS was signed by a LPN in section Z0500. 6) On 10/31/17 the surveyor reviewed the MDS of Resident #7. The Exec Order 26 § 4b1 Quarterly MDS was signed by a LPN in section Z0500. 7) On 10/31/17 the surveyor reviewed the MDS of Resident #8. The Exec Order 26 § Quarterly MDS was signed by a LPN in section Z0500. 8) On 11/1/17 the surveyor reviewed the MDS of Resident #22. The Exec Order 26 § 4 Quarterly MDS was signed by a LPN in section Z0500. 9) On 11/01/17 the surveyor reviewed the MDS of Resident #23. The Exec Order 26 § 4 Quarterly MDS was signed by a LPN in section Z0500. 10) On 11/2/17 at 11:08 a.m. the surveyor reviewed the MDS of Resident #9. The Exec Order 26 § 4 Quarterly MDS' were signed by a LPN in section Z0500.	F 278	4. The MDS coordinator will do a monthly audit of MDS assessments to ensure they are all signed by a Registered Nurse and report his findings to the QA committee on a quarterly basis for 1 year.	

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F 278	Continued From page 5	F 278		

11) On 11/2/17 at 11:08 a.m. the surveyor reviewed the MDS of Resident #10. The Exec Order 26 § 4 Quarterly MDS was signed by a LPN in section Z0500.

12) On 11/2/17 at 11:08 a.m. the surveyor reviewed the MDS of Resident #11. The Exec Order 26 § 4 Quarterly MDS' were signed by a LPN in section Z0500.

13) On 11/2.17 at 11:08 a.m. the surveyor reviewed the MDS of Resident #12. The Exec Order 26 § Quarterly MDS was signed by a LPN was signed by a LPN in section Z0500.

14) On 11/1/17 at 10:00 a.m. the surveyor reviewed the MDS of Resident #14. The Exec Order 26 § Quarterly MDS was signed by a LPN in section Z0500.

15) On 11/1/17 at 10:02 a.m. the surveyor reviewed the MDS of Resident #16. The Exec Order 26 Quarterly MDS and Exec Order 26 § Quarterly MDS was signed by a LPN in section Z0500

When interviewed on 11/01/17 at 1:00 p.m., the MDS Coordinator confirmed that the MDS' were signed by a LPN. The MDS coordinator further stated "I thought an LPN could sign the completion of the quarterly MDS and an RN should sign the Comprehensive MDS."

On 11/3/17 the surveyor reviewed the facility's Policy on the MDS which was provided by the Director of Nursing. The policy indicated that an RN Assessment Coordinator would be responsible for coordinating and signing each resident assessment. The policy also noted the Quarterly MDS assessments must be signed and

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F 278	Continued From page 6 dated by the RN Assessment Coordinator. The MDS section Z0500 on the MDS form notes "Signature of RN Assessment Coordinator Verifying Assessment Completion." The LPN was signing her name on the line that was required to be signed by an RN. NJAC 8:39 - 11.1	F 278		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 441		11/29/17

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F 441	Continued From page 7 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was	F 441	1. This Nurse was instructed on the policy	

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F 441	Continued From page 8 determined that the facility failed to follow appropriate hand hygiene practice. This deficient practice was observed for 1 of 2 nurses administering medication to 2 of 4 residents during the medication pass (Resident #27 and #28). This deficient practice was evidenced by the following: On 10/31/17 at 8:27 a.m. the surveyor observed the Licensed Practical Nurse (LPN) administer medications to Resident #27. The LPN then washed her hands for 10 seconds. On 10/31/18 at 8:30 a.m. the surveyor observed the same LPN prepare medication for administration to Resident #28. The resident was not available to take the medication, so the LPN disposed of the medication in the drug buster (a contained chemical solution that dissolves unused and unwanted medication on contact). The LPN then washed her hands for 12 seconds. On 10/30/17 at 11:00 a.m. the surveyor obtained a copy of the facility's "Handwashing Policy." According to the policy, all nursing and service staff should continue a scrubbing action for a period of 20 seconds when washing their hands with soap and water. NJAC 8:39-19.4(a)(1).	F 441	of hand washing in the facility. 2. All Residents can be affected by this deficient practice. 3. All staff are currently being re in-serviced on the proper hand washing procedure in the facility. 4. Random checks on hand washing will be conducted twice a month by each department head/designee for their department. The findings will be reported to the Infection Control coordinator who will report to the QA committee on a quarterly basis for 1 year.	