

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

PRINTED: 12/30/2024
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 04/11/2023
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	INITIAL COMMENTS Survey Dates: 04/03/23 through 04/06/23 Survey Census: 164 Sample Size: 47 Supplemental Residents: 0 A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. On 04/04/23 at 7:43 PM the U.S. FOIA (b)(6) [REDACTED] were notified of an Immediate Jeopardy (IJ) at F880-K: Infection Control related to the failure of the facility to ensure glucometers were cleaned and sanitized between resident use. The facility submitted an acceptable removal plan on 04/06/23 at 9:31 AM. The survey team validated the immediate jeopardy was removed on 04/06/2023 at 10:39 AM following the facility's implementation of the plan for removal of the immediate jeopardy. The deficient practice remained at an "E" (pattern of potential for more than minimal harm) scope and severity following the removal of the immediate jeopardy.	F 000			
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would	F 558		5/3/23	

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

TITLE

(X6) DATE

Electronically Signed

04/28/2023

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

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F 558	<p>Continued From page 1</p> <p>endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure a call light was within reach for four of four residents (Resident (R) 14, R41, R65, R68) reviewed for call lights out a total sample of 47 residents.</p> <p>Findings include:</p> <p>1. Review of R14's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed the resident was admitted to the facility on [redacted] with diagnoses of NJ Exec Order 26.4b1 [redacted].</p> <p>Review of R14's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] revealed the resident required NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. Further review revealed a "Brief Interview for Mental Status (BIMS)" score of NJ Exec Order 26.4b1 indicating R14 was [redacted].</p> <p>Review of R14's "Care Plan," initiated NJ Exec Order 26.4b1, located in the EMR under the "Care Plan" tab, revealed: "Resident is a [redacted]; Intervention: Keep call light and most frequently used personal items within reach. . ."</p> <p>During a concurrent observation and interview on 04/03/23 at 12:50 PM, R14 was observed lying in</p>	F 558	<p>F558</p> <p>1. The call light was unwrapped from the bedrail and was put in reach of resident #41 with [redacted] personal items placed with in reach. 1a. The call lights were placed within reach of resident #14, #41, #65, and #68.</p> <p>2. The unit manager did an audit on call lights, all call lights were within reach. Any resident who wants their call light in a specific place, or had a behavior with the call light, their care plan and kardex will be updated</p> <p>3. ADON and UM in-serviced all staff on checking for call light placement to be within reach of residents while in the residents rooms or placing the call light where the residents want it, and to place any issues into the Maintenance Log.</p> <p>4. ADON, UM, and Weekend Supervisor will audit all residents rooms for call light placement daily for 30 days, weekly for 1 month, and monthly for 2 months. Any issue from the audit will be corrected immediately, attached to the audit, and will reported during quarterly QAPI & QA.</p> <p>All findings or trends discovered during the audits will be brought to the QAPI committee for review at the monthly QAPI for three months.</p>		

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F 558	<p>Continued From page 2</p> <p>bed, unable to reach call light. R14 appeared [redacted] and stated [redacted] would like to be helped with [redacted].</p> <p>During an additional observation and interview on 04/04/23 at 8:42 AM, R14 was lying in bed, unable to reach the call light. R14 stated [redacted] needed to [redacted] but would have to wait until [redacted] could get some help when the staff made rounds.</p> <p>2. Review of R41's "Admission Record," located in the EMR under the "Profile" tab, revealed the resident was admitted to the facility on [redacted] with diagnoses of [redacted].</p> <p>Review of R41's quarterly "MDS" with an ARD of [redacted] revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of [redacted], which indicated the resident was [redacted] and the resident required [redacted] from the staff for [redacted] and [redacted] and was [redacted] on the staff for [redacted].</p> <p>Review of R41's "Care Plan," initiated [redacted] and located in the EMR under the "Care Plan" tab, revealed: "Resident is at [redacted]. Intervention: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance."</p> <p>During an observation on 04/03/23 at 10:03 AM, R41 was lying in bed, unable to reach the call light that was wrapped around the bedrail on the right side of the bed.</p> <p>During an observation and interview on, 04/03/23</p>	F 558			

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F 558	<p>Continued From page 4</p> <p>Ensure/provide a safe environment: Call light in reach."</p> <p>During an observation on 04/03/23 at 9:47 AM, R65 was observed lying in bed, the call light cord was lying on the floor along the wall behind the bed.</p> <p>During an additional observation and interview on 04/04/23 at 8:29 AM, R65 was lying in bed, the call light cord remained on the floor alongside the wall behind the bed. R65 could not find or reach the call light. When asked how to get in touch with the staff for assistance, R65 indicated, "They [staff] come in here."</p> <p>During an observation and interview on 04/05/23 at 8:36 AM, R65 was lying in bed with the call light cord hanging on the bedrail on the right side of the bed which was R65's NJ Exec Order 26.4b1 [REDACTED]. The surveyor placed the call light within reach and R65 was able to press the call light upon request.</p> <p>During an additional observation and interview on 04/06/23 at 9:27 AM, R65 was lying in bed with the call light cord hanging on the bedrail on the right side of the bed. R65 was unable to reach the call light.</p> <p>4. Review of R68's "Admission Record," located in the EMR under the "Profile" tab, revealed the resident was admitted to the facility on NJ Exec Order 26.4b [REDACTED] s.</p> <p>Review of R68's quarterly "MDS" with an ARD of NJ Exec Order 26.4b [REDACTED] revealed the resident required NJ Exec Order 26.4b1 [REDACTED]</p>	F 558			

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F 558	<p>Continued From page 5</p> <p>[NJ Exec Order 26.4b1] from the staff for [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] and was [NJ Exec Order 26.4b1] on the staff for [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1]. Further review revealed no "BIMS" score due to R68 being [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1].</p> <p>Review of R68's "Care Plan," initiated [NJ Exec Order 26.4b1] located in the EMR under the "Care Plan" tab, revealed the resident is: [NJ Exec Order 26.4b1]; Intervention: Ensure that call bell is within easy reach."</p> <p>During an observation on 04/03/23 at 9:59 AM, R68 was observed lying in bed with no available call light to call for assistance. The call light outlet was observed with no call light cord attached. There was no call light cord observed.</p> <p>During additional observations on 04/03/23 at 12:52 PM, and 04/04/23 at 8:34 AM, R68 was observed lying in bed without access to a call light. There was no call light cord observed.</p> <p>During a concurrent observation and interview on 04/05/23 at 8:36 AM, R68 was observed lying in bed, no call light available. Utilizing the call light cord of the adjacent bed, the surveyor requested R68 to press the call light. R68 was able to press the call light.</p> <p>During a concurrent observation and interview on 04/05/23 at 12:30 PM, the [US FOIA (b)(6)] observed the call light outlet with the surveyor and confirmed the call light cord was not present in the room.</p> <p>During an interview on 04/06/23 at 9:44 AM Licensed Practical Nurse (LPN) 5 stated she was unaware of the call light cord missing. LPN5</p>	F 558			

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F 558	Continued From page 6 stated that all residents should have and be able to reach their call lights. During an interview on 04/06/23 at 12:01 PM, the U.S. FOIA (b)(6) stated that the expectation is that all residents have a call light within reach. During an interview on 04/05/23 at 2:15 PM, the U.S. FOIA (b)(6) stated that the expectation is that the residents have a call light available and within reach. Review of policy titled "Answering the Call Light," reviewed July 2018, revealed "...be sure that the call light is plugged in at all times. . . When the resident is in the bed or confined to a chair be sure the call light is within easy reach of the resident."	F 558			
F 565 SS=D	NJAC 8:39-4.1(a)11 Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for	F 565		4/26/23	

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F 565	<p>Continued From page 7</p> <p>providing assistance and responding to written requests that result from group meetings.</p> <p>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.</p> <p>(A) The facility must be able to demonstrate their response and rationale for such response.</p> <p>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.</p> <p>§483.10(f)(6) The resident has a right to participate in family groups.</p> <p>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review, and policy review, the facility failed to facilitate resident council meetings for three of three consecutive months NJ Exec Order 26.4b1) and to consistently respond to issues and concerns presented by resident council members, and/or discuss and document its responses to the resident's grievances and recommendations with the Resident Council President (Resident (R) 79).</p> <p>Findings include:</p> <p>Review of the resident council meeting minutes for January 2023, February 2023, and March 2023 provided by the US FOIA (b)(6)</p>	F 565	<p>F565</p> <p>All residents have the potential to be affected by this deficient practice</p> <p>1. US FOIA (b)(6) were educated immediately on the frequency and importance of holding a resident counsel meeting. A resident council meeting was held immediately on 4/7/2023.</p> <p>1a. Director of Nursing (or designee) will audit resident council every month for six months. QAPI will meet monthly. AUDITS WILL BE BROUGHT TO MEETING FOR REVIEW BY QAPI TEAM.</p>		

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F 565	<p>Continued From page 8</p> <p>[REDACTED] 1 on 04/04/23 at 1:45 PM, revealed that the facility did not have resident council meetings for those three consecutive months. Furthermore, there were repetitive concerns from month to month without any documentation of the facility responses or of the concerns being addressed.</p> <p>Review of documents titled, "Residents' Council," for January 2023, February 2023, and March 2023 stated, "In lieu of resident's council meetings, activity staff were doing room-by-room visits during months of lockdown. Residents were asked if they have any concerns, ideas, and suggestions they would like to share. . . One-to-One visit to residents that attend Residents' Council regularly. . ."</p> <p>Review of documents titled, "Residents' Council, January 2023," stated a concern, " ... the food menu needs some changes and different options on the menu. . . food needs more taste . . ."</p> <p>Review of documents titled, "Residents' Council, February 2023," stated a concern, ". . . the food menu needs some changes and different options on the menu. . . "</p> <p>Review of documents titled, "Residents' Council, March 2023," stated a concern, " ... food needs some extra taste to it . . . the food is not always up to his liking . . . "</p> <p>During an interview on 04/04/23 at 1:55 PM, R 79, the [REDACTED], stated that the Resident Council had not had a meeting since December 2022 because of the renovations and because of the lockdown for COVID-19. R79 stated that Activities employees come around once a month and ask if anyone has any</p>	F 565	<p>2. Activities Director, Administrator, Nursing, Social Services, and Interdisciplinary Team met to review and revise resident council meeting to validate meeting times and facility responses to residents concerns.</p> <p>3. Activites Director and Social Services did an audit to address any pending concerns</p> <p>4. Administrator informed resident council members that resident council meetings are held on the 3rd Wednesday of each month.</p> <p>5. Will educate Dietary, Nursing dept., and interdisciplinary team on selective menus for residents to choose what they would prefer to eat</p> <p>6. Director of Nursing or designee will audit the meal service 1x/week x 4 weeks to validate menu selections. QAPI will meet monthly discuss meal selection. AUDITS WILL BE BROUGHT TO MEETING FOR REVIEW BY QAPI TEAM.</p> <p>7. Director of Dietary will take audit results to QAPI committee MONTHLY for review and recommendations.</p>		

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F 565	Continued From page 9 grievances, but no one follows up with him with the outcome or resolutions to the grievances. During an interview on 04/05/23 at 12:05 PM, the U.S. FOIA (b)(6) stated that the Resident Council had not met as a group since December 2022 due to the facility having been on lockdown for three months. The [redacted] stated members of the Resident Council were interviewed individually each month to allow them to voice concerns and grievances and to make recommendations. When asked how the residents' concerns were addressed, the [redacted] stated that the minutes were distributed to all department managers, so they could address the concerns that related to their department. The [redacted] stated that it was the responsibility of the department managers to follow up with the residents' concerns that related to their department. The [redacted] stated that Resident Council grievance responses were not documented on the minutes. The facility was unable to provide any documentation that any of the resident council concerns from January 2023, February 2023, and March 2023 were addressed. Review of the facility's policy titled, "Activity Department Resident Council Policy," revised April 2020," indicated, "Follow up to comments and concerns recorded in the minutes by utilizing a resident council response form. Keep minutes and completed response forms in a binder in the activity office."	F 565			
F 570 SS=F	NJAC 8:39-4.1(a) 24,29 Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi)	F 570			4/14/23

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F 570	<p>Continued From page 10</p> <p>§483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to have a surety bond in an amount large enough to cover the highest daily balance of the residents' trust fund account. This had the potential to affect 164 of 164 residents whose trust fund monies were held by the facility.</p> <p>Findings include:</p> <p>Review of the "Resident Fund Trust Account" bank statement, for the period of [redacted] through [redacted], revealed the lowest daily balance for the period was [redacted] on [redacted] and the highest daily balance for the period was [redacted] on [redacted].</p> <p>Review of the "Resident Fund Trust Account" bank statement, for the period of [redacted] through [redacted], revealed the lowest daily balance for the period was [redacted] on [redacted] and the highest daily balance for the period was [redacted] on [redacted].</p> <p>Review of the "Resident Fund Trust Account" bank statement, for the period of [redacted] [redacted] revealed the lowest daily balance for the period was [redacted] on [redacted] and the highest daily balance for the period was [redacted] on [redacted].</p> <p>During an interview on 04/05/23 at 7:03 PM, the</p>	F 570	<p>F570 All residents have the potential to be affected by this deficient practice</p> <p>1. Based on interview and record review, the facility failed to have a surety bond in an amount large enough to cover the highest daily balance of the residents' trust fund account. 1a. The resident's trust fund account balances were as follows: January 5, 2023 \$175,779.03 (high) January 31, 2023 \$168,944.98 (low) February 15, 2023 \$172,003.52 (high) February 28, 2023 \$165,181.78 (low) March 5, 2023 \$169,113.51 (high) March 31, 2023 \$161,153.73 (low)</p> <p>1b. The US FOIA (b)(6) [redacted] was educated on the proper way to read a surety bond. A new copy of the bond was printed and is kept in the business office.</p> <p>2. The surety bond was re-issued to the facility on 10/19/22 that read "on behalf of Abigail House for Nursing & Rehabilitation LLC, 1105-1115 Linden St, Camden, NJ 08101 in favor of Us Dept of Health & Human Services for the (extended) term</p>		

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F 570	Continued From page 11 US FOIA (b)(6)) provided a "Continuation Certificate" surety bond, dated NJ Exec Order 26.4b1, for the residents' trust account. The certificate indicated the bond was issued in the amount of NJ Exec Order 26.4b1 on behalf of Abigail House for Nursing and Rehabilitation in favor of the US Department of Health and Human Services for the term beginning on and ending on NJ Exec Order 26.4b1. The US FOIA (b) stated the facility's comptroller, who was unavailable for interview, stated it was a continuing bond. The US FOIA (b) stated she hoped there was another bond as this one was expired. The US FOIA (b) verified the bond was for NJ Exec Order 26.4b1 and was not enough to cover the funds in the resident trust account on any day for the last three months.	F 570	beginning on 12/25/22 and ending on 12/25/23, subject to all the covenants and conditions of said Bond, said bond and this and all continuation thereof being one continuous contract." 3. The new surety bond will be kept in the business office and it will be accessible at all times. The bond is updated annually and will be printed at the time it is updated by the facility Controller. 4. The Administrator/designee will monitor the surety bond quarterly for one year and annually, to ensure it is up to date and report to the QA Committee on a quarterly basis		
F 574 SS=E	NJAC 8:39-9.5(c)3 Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.	F 574		4/12/23	

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

PRINTED: 12/30/2024
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 04/11/2023
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F 574	Continued From page 12 (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;	F 574			

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F 574	<p>Continued From page 13</p> <p>(v) Contact information for the Medicaid Fraud Control Unit; and</p> <p>(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, observation, and record review, the facility failed to ensure information on the role of the US FOIA (b)(6) as an advocate was provided for three of three residents (Resident (R) 79, R46, and R88) reviewed in a total sample of 47 residents. This deficient practice resulted in the potential for lack of access to the NJ Exec Order 26.4b1</p> <p>Findings include:</p> <p>1. Review of R79's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed the resident was admitted to the NJ Exec Order 26.4b1</p> <p>Review of R79's quarterly "Minimum Data Set (MDS)," located in the EMR under the "MDS" tab, with an Assessment Reference Date (ARD) of U.S. FOIA (b)(6) revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of NU EP indicating R79 was NJ Exec Order 26.4b1.</p> <p>During an interview on 04/04/23 at 1:55 PM, R79</p>	F 574	<p>F574</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>1. Social Worker and Activities Director posted the contact numbers for the NJ Dept. of Health and the Ombudsman office. This posting was provided with information for what the contact numbers are used for and the purpose of its content.</p> <p>1b. The Ombudsman Officer was taken to meet residents #79, #46, and #88 in person to reintroduce the Ombudsman Officer.</p> <p>2. The facility identified all residents to have been affected and implemented a POC that will allow for all residents residing in the facility to have the corrected and current information regarding the NJ Dept of Health and Ombudsman office. All information will be presented during resident council meeting</p>		

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F 574	<p>Continued From page 14</p> <p>stated that [REDACTED] had been the [REDACTED] of the facility for a [REDACTED]. R79 was not aware that the facility had an ombudsman/resident advocate. Furthermore, R79 was not familiar with what an ombudsman was or who the facility's ombudsman was. [REDACTED] stated during his time as the [REDACTED], the ombudsman had not been to a resident council meeting, nor had [REDACTED] spoken with the ombudsman. R79 was unaware of how to contact the ombudsman.</p> <p>2. Review of R46's "Admission Record," located in the EMR under the "Profile" tab, revealed the resident was admitted to the facility on [REDACTED].</p> <p>Review of R46's quarterly "MDS," located in the EMR under the "MDS" tab, with an ARD of [REDACTED], revealed the resident had a "BIMS" score of [REDACTED], indicating R46 was [REDACTED].</p> <p>During an interview on 04/06/23 at 11:45 AM, R46 stated that [REDACTED] attended resident council meetings regularly and was not aware that the facility had an ombudsman/resident advocate. R46 was not familiar with what an ombudsman was or who the facility's ombudsman was. R46 was unaware of how to file a formal grievance with the ombudsman.</p> <p>3. Review of R88's "Admission Record," located in the EMR under the "Profile" tab, revealed the resident was admitted to the facility on [REDACTED] with [REDACTED].</p>	F 574	<p>as another precaution to ensure residents in the facility are aware of all new postings, content, and have the ability to view this information free from glares and at a comfortable stature regardless of physical condition</p> <p>3. All postings are hung throughout the facility for residents to view.</p> <p>4. Administrator or designee will ensure that the updated information remains in place, is accurate, and at an appropriate level for viewing. This will be checked once a week for for 4 weeks, and once a month for 3 months.</p> <p>5. The results of these audits will be reviewed in QAPI monthly x 6 months or until an average of 90% compliance of greater is acheived x3 consecutive months. The QAPI committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.</p>		

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F 574	Continued From page 15 NJ Exec Order 26.4b1 Review of R88's quarterly "MDS," located in the EMR under the "MDS" tab, with an ARD of NJ Exec Order 26.4b1 , revealed the resident had a "BIMS" score of NJ Exec Order 26.4b1 , indicating R88 was NJ Exec Order 26.4b1 . During an interview on 04/06/23 at 11:55 AM, R88 stated that NJ Exec Order 26.4b1 attended resident council meetings regularly and was not aware that the facility had an ombudsman/resident advocate. R88 was unaware of how to file a formal grievance with the ombudsman. R88 was not familiar with what an ombudsman was or who the facility's ombudsman was. During an interview on 04/05/23 2:15 PM, the U.S. FOIA (b)(6) stated the residents should be aware of how to file a grievance with the ombudsman and have access to the ombudsman's contact information.	F 574			
F 575 SS=E	NJAC 8:39-4.1(a)33 Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office	F 575		4/19/23	

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F 575	<p>Continued From page 16 of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to post in prominent locations the contact information for the Office of the State Long-Term Care Ombudsman program to include the name of the ombudsman, business address (mailing and email) and business number to ensure residents and resident representative were able to file a complaint. The resident census was 164 on the first day of survey.</p> <p>Findings include:</p> <p>Observations by five surveyors of the facility's lobby, hallways, resident units, and common areas of all three units throughout the entirety of the survey from 04/03/23 through 04/06/23, revealed the absence of postings of the contact information for the Office of the State Long-Term Care Ombudsman program.</p> <p>During an interview on 04/05/23 at 12:05 PM, the US FOIA (b)(6) confirmed the above required information was not posted. The US FOIA</p>	F 575	<p>F575</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>1. The posting was updated immediately to include the names, accurate phone numbers, or email addresses for aforementioned organizations and a statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directive requirements and requests for information regarding returning to the community.</p> <p>2. A walk through of the unit was conducted for other informational</p>		

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F 575	Continued From page 17 stated that the ombudsman contact information posting had been removed during facility renovations in December 2022. During an interview on 04/05/23 at 2:15 PM, the US FOIA (b)(6) stated the ombudsman posting had been removed during the renovations. NJAC 8:39-4.1(a)35	F 575	materialsto verify correct contact information. 3. Social Services will review the contact information posted quarterly to verify that the contact information is current. 4. Social Services or desginnee will audit the required posting monthly x 3, and quarterly for compliance to be sure accurate information remains posted. Results will be shared at the QAPI meeting. 5. Administrator/designee will audit posting daily for one week, then weekly x one month and will report to QAPI monthly and QA quarterly.		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse	F 578		5/10/23	

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F 578	<p>Continued From page 18</p> <p>medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, interview, and facility policy review, the facility failed to ensure that residents received assistance with formulating Advance Directives and had completed Physician's Orders for Life-Sustaining Treatment (POLST) forms for three (Residents (R)18, R93, and R76) of 12 residents reviewed for Advance Directives in a total sample of 47 residents.</p> <p>Findings include:</p> <p>1. Review of R18's "NJ Exec Order" scheduled "Minimum Data Set" (MDS), located in the electronic medical record (EMR) under the "MDS" tab, with an Assessment Reference Date (ARD) of</p>	F 578	<p>F578</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>1. The advanced directives and blank POLSTs for residents (18), R(93) and R(76) were clarified with medical doctors and residents and corrected immediately by the Unit Manager(s) and Social Services.</p> <p>2. An audit was completed on all residents by the Social Worker and Unit Managers to ensure the code status.</p>		

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F 578	<p>Continued From page 19</p> <p>U.S. FOIA (b)(6), revealed R18 was originally admitted to the facility on [redacted] and re-admitted to the facility on [redacted] with diagnoses that included NJ Exec Order 26.4b1 [redacted]. R18 had a "Brief Interview for Mental Status (BIMS)" score of [redacted] indicating [redacted].</p> <p>Review of R18's "Orders," located in the EMR under the "Orders" tab, revealed a physician's order dated [redacted] for a [redacted] code status.</p> <p>Review of care conference notes dated [redacted] obtained by the facility revealed R18 "is [redacted] and [redacted] and can make [redacted] ... is currently on [redacted] ... [redacted] has chosen to be [redacted] ..."</p> <p>Review of the paper chart for R18 revealed a blank POLST form in the chart. A POLST is used by emergency personnel during transport to identify the individual's wishes in the event of a medical emergency.</p> <p>2. Review of R93's quarterly "MDS," located in the EMR under the "MDS" tab, with an ARD of [redacted], revealed R93 was originally admitted to the facility on [redacted] and re-admitted to the facility on [redacted], and had no "BIMS" score recorded as R93 was [redacted].</p> <p>Review of R93's [redacted] "Orders," located in the EMR under the "Orders" tab, revealed a physician's order for [redacted].</p>	F 578	<p>3. The Unit Managers, Social Worker, the DON/ADON, MDS Coordinator to ensure the physician's order, DNR or full code request, EMAR, and care plan for any admitting resident is the same. Inservices provided to all nursing staff and Social Workers on advanced directives.</p> <p>4. The Social Worker will audit 10 charts each week for eight weeks, then 5 charts for 4 weeks to ensure code status information, including written physician orders, EMAR, code request, and care plan all the same. The Social Worker will report any findings immediately to the DON/designee. The Social Worker will report any findings to the QAPI committee monthly for 3 months.</p>		

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F 578	<p>Continued From page 20</p> <p>NJ Exec Order 26.4b1</p> <p>Review of the paper chart for R18 revealed a blank POLST form.</p> <p>During an interview with the Social Service Director (SSD)1 on 04/04/23 5:45 PM, she presented an Advance Directive form which the SSD1 stated she presented to residents and their representatives but stated most residents declined to complete it. The SSD1 further stated she presented the Advance Directives form to the residents when she did her initial social service assessment with the residents.</p> <p>During an interview with the U.S. FOIA (b)(6) on 04/04/23 at 7:08 PM, the U.S. FOIA (b)(6) stated the facility did have an Advance Directives policy which addressed what residents want medically in their care, and this is discussed during care conferences by the social worker. The US FOIA (b)(6) further stated that during admission, the office assistant goes over Advance Directives information in the admission packet with residents.</p> <p>Interview with the US FOIA (b)(6) on 04/06/23 at 10:00 AM revealed that she or the US FOIA (b)(6) explained Advance Directives to residents on admission. The US FOIA (b)(6) stated a resident handbook is given to the resident and they are told to bring their Advance Directives if they have one. When asked how Advance Directives are explained to the resident, she stated all she does is give the resident handbook to the resident, give them "a heads up" of what is written in the handbook, and it is then "up to" the social services to explain Advance Directives to the resident. The US FOIA (b)(6) further stated</p>	F 578			

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F 578	<p>Continued From page 21</p> <p>she explains an Advance Directive as a living will, in which a person decides if they want to be on a ventilator and other lifesaving measures and asks if the resident has one or not and have them sign the acknowledgement about Advance Directive information in their admission packet. The [REDACTED] acknowledged that she had the residents sign the admission agreement stating that they understood and had received Advance Directions information. The [REDACTED] stated she deferred the explanations of how to formulate Advance Directives to social services.</p> <p>Review of the facility's policy titled "Advance Directives," reviewed 7/2018, revealed as follows: "1. At the time of or prior to admission, the Facility shall provide the resident and/or the responsible party with a copy of Your Right to Make Health Care Decisions in New Jersey; 2. The resident and/or the responsible party will be asked to acknowledge receipt of the above information in writing. This acknowledgment will be maintained in the Business Office file. 3. The Admissions Director or designee will inquire as to the existence of an Advance Directive. If a Directive has been executed, the Director or designee will ask that a copy be provided to the Facility. The Social Worker will do necessary follow-up ... 10. Upon admission/readmission, the Advance Directive will be reviewed in care planning or in a meeting with the Social Worker, Director of Nursing and Resident. Thereafter, the Advance Directive will be reviewed quarterly with the Resident, if appropriate."</p> <p>NJAC 8:39-4.1(a)2 NJAC 8:39-9.6(a)</p>	F 578			

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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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F 585 SS=E	<p>Grievances CFR(s): 483.10(j)(1)-(4)</p> <p>§483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.</p> <p>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.</p> <p>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.</p> <p>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for</p>	F 585		4/12/23	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 585	Continued From page 23 completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be	F 585			

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F 585	<p>Continued From page 24</p> <p>taken by the facility as a result of the grievance, and the date the written decision was issued;</p> <p>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and</p> <p>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interviews, record review, and policy review, the facility failed to make prompt efforts to resolve grievances, document evidence of investigations and resolutions for five of 12 grievances provided by the facility for review. Additionally, the facility failed to discuss the resolution or lack thereof with residents and family members.</p> <p>Findings include:</p> <p>Review of documents titled, "Resident Concern Report," provided by the Director of Social Work (SSD) 2 from a binder located in her office, revealed five resident concern reports without resolution statements, documentation of the date that the grievance was turned over to the Social Work Department, the date the grievance with either resolved or unresolved, and/or if the resolution or the lack thereof was discussed with the resident or family.</p> <p>During an interview on 04/04/23 at 2:48 PM with</p>	F 585	<p>F585</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>Residents have a right to make grievances with the Social Worker.</p> <p>A grievance will be filled out and distributed to departments that are involved for the investigation based on the concern for a prompt resolution.</p> <p>Statement will be made by the staff involved to resolve the grievance.</p> <p>A date to return to the social worker with a resolution will be within the facility guidelines.</p> <p>Social Workers will check in a week to see if the grievance has been resolved</p>		

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F 585	<p>Continued From page 25</p> <p>the SSD1, she stated the grievances that are heard by the social workers are written up on a concern form and sent to the department manager of which the grievance correlates. SSD1 stated that the department managers follow up on their own grievances. SSD1 stated that she does not maintain a grievance log.</p> <p>During an interview on 04/04/23 at 3:00 PM, SSD2 stated, "I write up the grievances that are given to me and pass them along to the department that they belong to, and I give the U.S. FOIA (b)(6) a copy." SSD2 also stated that the U.S. FOIA (b)(6)) also takes grievances. SSD2 stated that she does not maintain a grievance log.</p> <p>During an interview on 04/05/23 at 12:05 PM, the U.S. FOIA (b)(6) stated that the department managers maintain and follow up with resident grievances. She stated that any grievances heard in the resident council meetings are taken to the department meetings and distributed to the appropriate manager for that grievance.</p> <p>During an interview on 04/06/23 at 11:56 AM, the U.S. FOIA (b)(6) stated that the social workers document all grievances on a concern report and the facility investigates the grievance until a resolution is reached. The U.S. FOIA (b)(6) stated that any of the department managers could be responsible for following up on grievances, depending on the type of complaint. The U.S. FOIA (b)(6) stated the grievance officers in the facility are the social workers.</p> <p>During an interview on 04/05/23 at 2:15 PM, the U.S. FOIA (b)(6) stated that the social workers are the grievance officers for the facility, they should</p>	F 585	<p>If the grievance is alleged to be abuse, including injuries of unknown source, these grievances will be reported to nurse managers, DON, and the Administrator so that it can be reported to the state in a timely fashion. The Social Workers will follow up with the staff involved to ensure the investigation is completed in accordance with Abigail House policy.</p> <p>An audit of Grievance/Concern forms for 30 days was completed by the Administrator as of 4/10/23 to determine if they were completed in their entirety and the resolution was presented to the named Resident or the Resident's responsible party and a copy given to the resident per his/her wishes.</p> <p>Of those found not to be fully completed, 100% are completed as of 4/11/23 and the resolution communicated to the resident/family.</p> <p>100% of Department Managers were re-educated as of 4/7/23 regarding the Grievance/Concern policy and the importance of completing the Grievance/Concern forms correctly, resolving the concern, communicating to the resident and/or family and giving them a written resolution per his/her wishes. All newly hired Department Managers will be educated at the time of hire.</p> <p>100% of the staff were re-educated regarding F585 and the importance of</p>		

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F 585	Continued From page 26 follow up on all grievances, and maintain a grievance log. Review of facility policy titled, "Resident Grievances/Resolutions-Use of the Concern Report," reviewed July 2018, indicated "When a concern is resolved, the Social Worker will notify all departments involved of the resolution by distributing a copy of the resolution statement on the concern report form. The completed form is kept on file in a notebook with Social Services. The grievance forms are kept for 3 years. Notification of final outcome in written form will be given to the individuals filing the complaint by the social worker or designee. If a concern has not been resolved in a reasonable amount of time, the Social Worker will reexamine the situation and make a second attempt at the process." NJAC 8:39-4.1(a)35 NJAC 8:39-13.2(c)	F 585	reporting, documenting, and resolving grievances as of 4/7/23. Newly hired staff will be educated regarding the Grievance policy at time of hire. The Social Worker will ensure that all Grievances/Concerns will be logged, the resolution is accomplished and the resolution is communicated to the resident/family. The Administrator/designee as the Grievance Official will review all. Grievances/Concerns and validate that the form is completed in its entirety and the results have been communicated to the complainant. Upon validating the completion and resolution, the Administrator will sign the form. The Administrator/designee will audit Grievance and Concern forms daily for 2 weeks, monthly for 3 months, to ensure that the form is completed in its entirety and the results have been communicated to the resident in the method of their preference. The Administrator/designee will compile a report on the findings of these audits monthly and report to the QAPI committee monthly. The QAPI committee will make changes to the plan as necessary. The facility Administrator and DON will be responsible for the implementation of this plan of correction to ensure the facility attains and maintains compliance.		
F 644 SS=E	Coordination of PASARR and Assessments	F 644		5/23/23	

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F 644	<p>Continued From page 27 CFR(s): 483.20(e)(1)(2)</p> <p>§483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:</p> <p>§483.20(e)(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.</p> <p>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete NJ Exec Order 26.4b1 accurately and/or with new NJ Exec Order 26.4b1 diagnoses for three (Resident (R) 152, R34, and R141) of 47 sampled residents.</p> <p>Findings include:</p> <p>1. Review of R152's "Admission Record," located under the "Profile" tab of the electronic medical record, revealed R152's principal admitting on diagnosis on NJ Exec Order 26.4b1.</p> <p>Review of R152's NJ Exec Order 26.4b1</p>	F 644	<p>F644</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>1. Resident #152, #34, and #141 NJ Ex Order 26.4b1 were reviewed and corrected</p> <p>2. All residents PASRRs were audited by the Social Workers to include new diagnoses.</p> <p>3. The Social Worker was provided the PASSR manual with forms. The Administrator completed an in-service for the Social Workers related to completing</p>		

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F 644	<p>Continued From page 28</p> <p>NJ Exec Order 26.4b1, " dated NJ Exec Order 26.4b1 and located under the "Misc" tab of the EMR, indicated, " . . . Does the individual have a diagnosis or evidence of a NJ Exec Order 26.4b1 limited to the following disorders . . . NJ Exec Order 26.4b1 . . . " The form was marked NJ Exec Order 26.4b1 and signed by Director of Social Work (SSD) 1.</p> <p>During an interview on 04/05/23 at 9:00 AM, SSD1 verified she had completed the NJ Exec Order 26.4b1 screening for R152. SSD1 stated she had obtained the diagnoses to complete the form from R152's Admission Record. SSD1 reviewed R152's Admission Record and stated she was just seeing R152 had a diagnosis of NJ Exec Order 26.4b1 on admission. SSD1 stated she would have to redo the NJ Exec Order 26.4b1 for R152. SSD1 stated she did not know what the facility's policy was for completing or reviewing NJ Exec Order 26.4b1 screenings.</p> <p>During an interview on 04/05/23 at 3:18 PM, the U.S. FOIA (b)(6) stated there was no policy on reviewing NJ Exec Order 26.4b1 forms. The U.S. FOIA (b)(6) stated the forms were completed and placed in the residents' files.</p> <p>2. Review of R34's undated "Face Sheet," located in the electronic medical record (EMR) under the "Face Sheet" tab revealed the resident was admitted to the facility on NJ Exec Order 26.4b1 a readmission date of NJ Exec Order 26.4b1, with diagnoses including NJ Exec Order 26.4b1. Further review of the resident's face sheet revealed the diagnoses of NJ Exec Order 26.4b1.</p> <p>Review of R34's NJ Exec Order 26.4b1</p>	F 644	<p>a new screening for the PASSR. Social Worker will review and audit all PASSRs upon admission, monthly, and with any new related diagnosis. Level II screening will be submitted accordingly and timely.</p> <p>4.The Social Worker will complete a 100% audit of Level I or II PASSR upon admission and as needed with any new MD or related condition. The Social Worker will report his/her audit to the Administrator and QAPI committee monthly 3x months for compliance.</p>		

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F 644	<p>Continued From page 29</p> <p>NJ Exec Order 26.4b1, " dated NJ Exec Order 26.4b1, located in the resident's EMR under the "Documents" tab revealed, "Section B: Level One Screening Criteria for NJ Exec Order 26.4b1 NJ E Has this person ever been diagnosed as having a NJ Exec Order 26.4b1 : NJ Exec NJ Exec " Further review of R34's entire EMR revealed there was no additional documented evidence of a NJ Exec Order 26.4b1 assessment being completed after the diagnoses of NJ Exec Order 26.4b1</p> <p>During an interview on 04/05/23 at 9:09 AM, the Social Services Director (SSD)1 stated, she was unaware a new NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 was required to be completed for a new NJ Exec Order 26.4b1 diagnosis. She stated that she is not made aware when residents receive new mental diagnoses from physicians. When NJ Exec Order 26.4b1 are received from hospitals they are downloaded and filed.</p> <p>During an interview on 04/05/23, at 11:23 AM, LPN 3 stated, any information about a new NJ Exec Order 26.4b1 for a resident would be passed on to social services in a morning meeting.</p> <p>During an interview on 04/05/23, at 11:45 AM the Administrator said NJ Exec Order 26.4b1 screenings are completed by hospital staff and sent in the resident's admission paperwork. He said this information is filed. He did not know the information should be reviewed or updated when there are new diagnoses.</p> <p>3. Review of R141's "Admission Record," located in the "Profile" tab of EMR revealed R141 was admitted to the facility or NJ Exec Order 26.4b1 with diagnoses that included NJ Exec Order 26.4b1 ,</p>	F 644			

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F 644	<p>Continued From page 30</p> <p>NJ Exec Order 26.4b1</p> <p>[REDACTED]</p> <p>Review of R141's NJ Exec Order 26.4b1 dated NJ Exec Order 26.4b1 and provided by the facility, revealed a check of NJ Exec Order 26.4b1 to whether R141 had a diagnosis of a NJ Exec Order 26.4b1.</p> <p>During an interview with the Social Services Director (SSD) 2 on 04/06/2023 at 12:22 PM the SSD2 stated when residents are admitted with a NJ Exec Order 26.4b1 screen from the hospital, it is reviewed to see if it is positive or not. SSD2 stated the NJ Exec Order 26.4b1 are not reviewed for accuracy. Once it is determined whether they are positive or negative (whether a level II screen is required), "we don't ever look at them again."</p> <p>During an interview with the U.S. FOIA (b)(6) on 04/05/23 at 3:18 PM, the U.S. FOIA (b)(6) stated the NJ Exec Order 26.4b1 comes with the admission paperwork for the resident and is filed in the chart. There is no process to review the form, it goes in the file. The U.S. FOIA (b)(6) further stated that he did not know if a new NJ Exec Order 26.4b1 is needed when the resident has a new major NJ Exec Order 26.4b1, or if or how that is communicated to Social Services.</p> <p>Review of the undated policy provided by the facility titled "Preadmission Screening and Annual Resident Review (PASARR) Policy" revealed, "It is the policy to screen all potential admissions on an individualized basis. As part of the preadmission process, the facility participates in the Preadmission Screening and Resident Review (PASARR) screening process (Level I) for</p>	F 644			

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F 644	Continued From page 31 all new and readmissions per requirement to determine if the individual meets the criterion for mental disorder (SMI/SMD), intellectual disability (ID) or related condition. Based upon the Level I screen, the facility will not admit an individual with a mental disorder or intellectual disability until the Level II screening process has been completed and the recommendations allow for a nursing facility admission and the facility's ability to provide the specialized services determined in the Level II screen."	F 644			
F 656 SS=D	NJAC 8:39-5.1(a) 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		5/24/23	

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F 656	<p>Continued From page 32</p> <p>(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.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(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.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review, and interview, the facility failed to develop all care plans for two residents (Resident (R)76 and R159) out of a total sample of 47 residents.</p> <p>Findings include:</p> <p>1. Review of R76's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed the resident had diagnoses that included NJ Exec Order 26.4b1 ().</p>	F 656	<p>F656</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>1. Resident #76 and #159 had their care plans reviewed and updated.</p> <p>2. DON/designee inserved [REDACTED] and Unit Managers on reviewing and updating residents care plans</p>		

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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		
(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	<p>Continued From page 33</p> <p>Review of R76's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted], located in the EMR "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of [redacted] which indicated R76 had [redacted] NJ Exec Order 26.4b1. R76 also exhibited signs and symptoms of [redacted] NJ Exec Order 26.4b1. Further review of this "MDS" revealed R76 had an active diagnosis of [redacted] NJ Exec Order 26.4b1 and received [redacted] NJ Exec Order 26.4b1 daily.</p> <p>Review of the resident's [redacted] NJ Exec Order 26.4b1 evaluation, dated [redacted] NJ Exec Order 26.4b1 and located in EMR "Miscellaneous" tab, revealed diagnoses which included PTSD, [redacted] NJ Exec Order 26.4b1. The resident is [redacted] NJ Exec Order 26.4b1 since last evaluation [redacted] NJ Exec Order 26.4b1. Resident currently on [redacted] NJ Exec Order 26.4b1 and does not want to change the medication since the resident is showing some [redacted] NJ Exec Order 26.4b1.</p> <p>Review of R76's "Care Plan," dated [redacted] NJ Exec Order 26.4b1 and located in the EMR "Care Plans" tab, revealed interventions for [redacted] NJ Exec Order 26.4b1 but did not address the resident's [redacted] NJ Exec Order 26.4b1 diagnosis and/or [redacted] NJ Exec Order 26.4b1.</p> <p>2. Observation on 04/04/23 at 11:53 AM revealed R159 [redacted] NJ Exec Order 26.4b1. The resident maintained [redacted] NJ Exec Order 26.4b1. R159 was sitting in [redacted] NJ Exec Order 26.4b1 wheelchair with [redacted] NJ Exec Order 26.4b1. The resident had an [redacted] NJ Exec Order 26.4b1.</p> <p>Review of R159's "Admission Record," located in</p>	F 656	<p>3. MDS Coordinator will audit care plans daily for 1 week, than weekly for 4 weeks, then monthly and report to QA monthly and to QAPI quarterly, for current residents to ensure all residents have proper care plans in place, to include wound care and smoking interventions.</p> <p>4. MDS Coordinator will audit care plans for new admits daily for a week, then weekly for a 1 month, then monthly and report to QA to ensure compliance & to QAPI quarterly. MDS inserviced on ensuring accuracy of care plan interventions on 4/7/23 by DON/designee.</p> <p>5. Don/designee will monitor audit from MDS weekly times 4 weeks, then monthly to report to QA & QAPI quarterly.</p> <p>6. Results will be forwarded to QA for further recommendations and review by DON/designee.</p>		

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F 656	Continued From page 34 the EMR "Profile" tab, documented the resident was admitted to the facility on [U.S. FOIA (b)(6)] with diagnoses that included ar [NJ Exec Order 26.4b1] Review of the resident's admission "MDS" with an ARD of [NJ Exec Order 26.4b1], located in the EMR "MDS" tab, documented a "BIMS" score of [NJ Exec Order 26.4b1] which indicated R159's [NJ Exec Order 26.4b1]. The resident was assessed to have [NJ Exec Order 26.4b1] Review of the monthly physician's orders, located in the EMR "Orders" tab, documented the resident was to have [NJ Exec Order 26.4b1] Review of the resident's [NJ Exec Order 26.4b1] assessment," dated [NJ Exec Order 26.4b1] and located in the EMR "Assessments" tab, documented the resident could [NJ Exec Order 26.4b1] with supervision. Review of the resident's "Care Plan," dated [NJ Exec Order 26.4b1] located in the EMR "Care Plans" tab, revealed the care plan did not address the physician ordered [NJ Exec Order 26.4b1] care or [NJ Exec Order 26.4b1] interventions for R159. Interview with the Licensed Practical Nurse (LPN) 4 on 04/06/23 at 11:10 AM revealed that she was responsible for developing and revising the resident care plans. LPN 4 acknowledged care plans were not developed to reflect R76's diagnosis of [NJ Exec Order 26.4b1] or R159's [NJ Exec Order 26.4b1] care.	F 656			
F 657 SS=D	NJAC 8:39-11.2(e) Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		5/26/23	

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F 657	<p>Continued From page 35</p> <p>§483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, interview, and review of facility policy, the facility failed to revise care plans for one resident (Resident (R)64) out of a total sample of 47 residents.</p> <p>Findings include:</p> <p>Observation 04/06/23 at 2:10 PM revealed R64 lying on a NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1. The head of bed</p>	F 657	<p>F657</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>1. Care plan for resident #64 was updated to include all plan of care</p> <p>2. In-serviced all staff on care plan</p>		

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F 657	<p>Continued From page 36</p> <p>(HOB) was NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 (name of NJ Exec Order 26.4b1) was hanging with the pump turned off with NJ Exec Order 26.4b1 R64 was observed NJ Exec Order 26.4b1.</p> <p>Review of R64's "Admission Sheet," located in the EMR "Profile" tab, documented the resident was admitted with diagnoses that included U.S. FOIA (b)(6)</p> <p>Review of the resident's Medicare five-day "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b1, located in the EMR "MDS" tab, documented a "BIMS" score of NJ Exec Order 26.4b1 which indicated R64 had NJ Exec Order 26.4b1 on staff for all activities of daily living, was NJ Exec Order 26.4b1</p> <p>Review of the monthly "Physicians Orders," in the EMR "Orders" tab, revealed R64 was to be NJ Exec Order 26.4b1; and NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 each hour for 12 hours.</p> <p>Review of the resident's "Care Plan," dated NJ Exec Order 26.4b1 in the EMR "Care Plans" tab, documented R64 was receiving a NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 in addition to the NJ Exec Order 26.4b1. The care plan identified the resident had NJ Exec Order 26.4b1, but it did not include the NJ Exec Order 26.4b1 for the resident's NJ Exec Order 26.4b1 as an intervention to prevent NJ Exec Order 26.4b1.</p>	F 657	<p>revision, including US FOIA (b)(6)</p> <p>3. DON/designee to audit at random 20% of care plans x3 months for accuracy. MDS inserviced on 4/6/23 to properly update care plan and to report status to DON/designee</p> <p>4. Results will be forwarded to monthly QAPI for further discussion and follow up by DON/designee</p>	

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F 657	Continued From page 37 On 04/06/23 at 2:55 PM an interview was conducted with Licensed Practical Nurse (LPN) 4. She stated nursing was responsible for the development and revision of the care plan. LPN4 reviewed R64's care plan and agreed the care plan should have been revised to reflect the resident was no longer receiving an [NJ Exec Order 26.4b1] with [NJ Exec Order 26.4b1] and the use of the [NJ Exec Order 26.4b1].	F 657			
F 677 SS=E	NJAC 8:39-11.2(h) 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: Based on observation, interview, record review, and policy review, the facility failed to provide assistance with [NJ Exec Order 26.4b1] care, [NJ Exec Order 26.4b1], and/or [NJ Exec Order 26.4b1] care for three (Resident (R) 30, R41, and R65) of 47 sampled residents. Findings include: 1. Review of R30's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR) revealed R30 was admitted with diagnoses that included U.S. FOIA (b)(6) Review of R30's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of [NJ Exec Order 26.4b1], located in the EMR under the "MDS" tab, revealed R30 had a "Brief Interview	F 677	F677 1.Facility failed to provide assistance with care to residents #30, #41, #65. All residents [NJ Exec Order 26.4b1] of staff for [NJ Exec Order 26.4b1] have the potential to be affected. Residents #30, #41, and #65 were immediately taken to the [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1] took place, as well as [NJ Exec Order 26.4b1] care. 2. Audit completed to identify all residents dependent on staff for bathing, nail care, facial grooming, and all hair care. Those residents identified that did not receive	5/10/23	

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F 677	<p>Continued From page 38 for Mental Status (BIMS)" score of [redacted] which indicated R30 was [redacted]. The MDS indicated R30 required limited assistance of one staff member for [redacted].</p> <p>Review of R30's "Care Plan," last revised [redacted] and located under the "Care Plan" tab of the EMR, indicated R30 had a problem related to [redacted] and staff was to assist R30 with activities of daily living, as necessary.</p> <p>Review of R30's "Treatment Records," dated [redacted] and located under the "Orders" tab of the EMR, revealed no documentation of [redacted] for R30.</p> <p>Review of R30's "Task Records," dated [redacted] and located under the "Tasks" tab of the EMR, revealed no documentation of [redacted] for R30.</p> <p>During a concurrent interview and observation on 04/03/23 at 10:52 AM, R30's [redacted].</p> <p>The [redacted] on R30's [redacted] R30's [redacted]. R30 stated [redacted] did not like [redacted] and [redacted] but staff told [redacted].</p> <p>During an interview on 04/05/23 at 3:22 PM, Certified Nurse Aide (CNA) 1 stated the CNAs could [redacted] R30's [redacted] because [redacted] was a [redacted] CNA1 stated [redacted] R30's [redacted] would be the responsibility of the nurse.</p>	F 677	<p>shower/bath were offered a shower/bath per schedule.</p> <p>3. All Nursing staff in-serviced by ADON/Unit Manager on process of bathing schedules, and entering shower/bath on POC</p> <p>4. Bathing will be completed daily per shower/bath schedules, any missed shower/bath will be investigated, and POC updated</p> <p>6. Any resident who declines a shower/bath will be addressed by Unit Manager/Nurse to ensure resident is being offered a shower/bath per preference</p> <p>7. Bathing will be reviewed and discussed daily in clinical meeting which is overseen by DON/designee</p> <p>8. Any missing bathing documentation will be reported on daily POC form to ensure follow up is complete.</p> <p>9. POC report will be reviewed daily and reported to DON/designee and re-education will be completed as indicated.</p> <p>10. Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the DON/designee.</p>		

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F 677	<p>Continued From page 39</p> <p>During an interview on 04/05/23 at 3:27 PM, Licensed Practical Nurse (LPN) 7 stated nurses were responsible for NJ Exec Order 26.4b1 for R30 and she did not know the last time R30's NJ Exec Order 26.4b1 had been NJ Exec Order 26.4b1. LPN7 stated she had recently asked R30 if she could NJ Exec Order 26.4b1, but NJ Exec Order 26.4b1 had refused.</p> <p>During an observation on 04/05/23 at 3:33 PM, LPN7 was asked to confirm the length of R30's NJ Exec Order 26.4b1. LPN7 removed NJ Exec Order 26.4b1 from the medication cart and entered R30's room. Without speaking, R30 stretched out NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 LPN7 confirmed the NJ Exec Order 26.4b1 should not be left to NJ Exec Order 26.4b1 to that NJ Exec Order 26.4b1 for R30.</p> <p>During an interview on 04/06/23 at 5:24 PM, the US FOIA (b)(6) stated the expectation was for staff to complete NJ Exec Order 26.4b1 as needed.</p> <p>Review of the facility's policy titled, "Nail Care Policy," revised July 2018, revealed, ". . . All residents at Abigail House will receive proper nail care as part as [sic] their daily care, as appropriate . . ."</p> <p>2. Review of R41's "Admission Record," located in the EMR under the "Profile" tab, revealed the resident was admitted to the facility on NJ Exec Order 26.4b1 with diagnoses of NJ Exec Order 26.4b1</p> <p>NJ Exec Order 26.4b1</p> <p>Review of R41's quarterly "MDS" with an ARD of NJ Exec Order 26.4b1 revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of NJ Exec Order 26.4b1, which indicated R41 was NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 on</p>	F 677	11. Bathing audit will be completed weekly x 4 weeks, monthly x 6 months, and quarterly thereafter until compliance is acheived.		

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F 677	<p>Continued From page 40 the staff for NJ Exec Order 26.4b1</p> <p>Review of R41's "Care Plan," initiated NJ Exec Order 26.4b1 and located in the EMR under the "Care Plan" tab, revealed: "R 41 requires NJ Exec Order 26.4b1 Intervention: R41 NJ Exec Order 26.4b1."</p> <p>During an observation and interview on, NJ Exec Order 26.4b1 at 10:03 AM, R41 was NJ Exec Order 26.4b1. R41 indicated to the surveyor that NJ Exec Order 26.4b1 would like a NJ Exec Order 26.4b1 but would need assistance. R41's NJ Exec Order 26.4b1, with a NJ Exec Order 26.4b1 and around the NJ Exec Order 26.4b1</p> <p>During an additional observation on 04/04/23 at 8:45 AM, R41 was observed lying in bed, appearing NJ Exec Order 26.4b1</p> <p>NJ Exec Order 26.4b1 R41 reported that NJ Exec Order 26.4b1 had not received assistance with NJ Exec Order 26.4b1</p> <p>On 04/06/23 at 9:40 AM, Licensed Practical Nurse (LPN)5 and Certified Nursing Assistant (CNA)5 both verified R41's NJ Exec Order 26.4b1 were NJ Exec Order 26.4b1</p> <p>3. Review of R65's "Admission Record," located in the EMR under the "Profile" tab revealed the resident was admitted to the facility on NJ Exec Order 26.4b1</p> <p>Review of R65's annual "MDS" with an ARD of NJ Exec Order 26.4b1 revealed the resident was totally dependent on the staff for NJ Exec Order 26.4b1. Further review revealed no "BIMS" score due to</p>	F 677		

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F 677	<p>Continued From page 41</p> <p>not being able to assess R65 due to he [redacted] NJ Exec Order 26.4b1</p> <p>Review of R65's "Care Plan," initiated [redacted] NJ Exec Order 26.4b1 and located in the EMR under the "Care Plan" tab, revealed: "has a NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4b1</p> <p>Goal: To be [redacted] NJ Exec Order 26.4b1, [redacted] NJ Exec Order 26.4b1, and [redacted] NJ Exec Order 26.4b1 daily . . ."</p> <p>During an observation on 04/03/23 at 9:47 AM, R65 was observed lying in bed, appearing [redacted] NJ Exec Order 26.4b1.</p> <p>During an observation and interview on 04/04/23 at 8:29 AM, R65 was observed lying in bed, [redacted] NJ Exec Order 26.4b1. R65 stated that staff had not assisted [redacted] NJ Exec Order 26.4b1.</p> <p>During an observation on 04/05/23 at 8:36 AM, R65 was observed lying in bed, with [redacted] NJ Exec Order 26.4b1, appearing the same as it had the day before.</p> <p>During an additional observation and interview on 04/06/23 9:27 AM in the resident's room, R65's [redacted] NJ Exec Order 26.4b1 as it had been during the entirety of the survey from [redacted] NJ Exec Order 26.4b1. When asked how long it had been since the staff had helped [redacted] NJ Exec Order 26.4b1, R65 [redacted] NJ Exec Order 26.4b1.</p> <p>During an observation on 04/06/23 at 5:22 PM, R65 was observed sitting in a wheelchair at the nurse's station, outside of the dayroom. R65's [redacted] NJ Exec Order 26.4b1. When R65 was</p>	F 677			

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F 677	Continued From page 42 asked if NJ Exec Order 26.4b1 [REDACTED] During an interview on 04/05/23 at 12:42 PM, LPN 5 stated the U.S. FOIA (b)(6) are to assist with resident's daily care. LPN5 stated the U.S. FOIA (b)(6) are to make sure the residents are NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 are NJ Exec Order 26.4b1 During an interview on 04/06/23 at 12:01 PM, the U.S. FOIA (b)(6) stated the expectation of the staff is to assist the residents with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 . The U.S. FOIA (b)(6) stated residents are to have NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 if they prefer, with their NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and their NJ Exec Order 26.4b1 .	F 677			
F 686 SS=D	NJAC 8:39-27.2(g) Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686		4/25/23	

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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		
(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 686	<p>Continued From page 43</p> <p>by: Based on observation, interview, record review, and facility policy review, the facility failed to consistently implement necessary treatment and services to a [NJ Exec Order 26.4b1] to for one of five residents (Resident (R)41) reviewed for [NJ Exec Order 26.4b1] out of total sample of 47 residents</p> <p>Findings include:</p> <p>Review of R41's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed the resident was admitted to the facility on [NJ Exec Order 26.4b1] with diagnoses of [NJ Exec Order 26.4b1]</p> <p>Review of R41's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [NJ Exec Order 26.4b1] revealed a "Brief Interview for Mental Status (BIMS)" score of [NJ Exec Order 26.4b1], which indicated R41 was [NJ Exec Order 26.4b1] required [NJ Exec Order 26.4b1] from the staff for [NJ Exec Order 26.4b1], and was at risk of developing [NJ Exec Order 26.4b1]. Further review of this "MDS" revealed R41 had no [NJ Exec Order 26.4b1] and had a [NJ Exec Order 26.4b1] on the bed and chair.</p> <p>Review of R41's "Care Plan," initiated [NJ Exec Order 26.4b1] and located in the EMR under the "Care Plan" tab, listed the "focus" for R 41 as "has potential [NJ Exec Order 26.4b1] related to [NJ Exec Order 26.4b1]. The care plan listed the "interventions" initiated [NJ Exec Order 26.4b1] as "Treatment ordered by [U.S. FOIA (b)(6)] and initiated ... [NJ Exec Order 26.4b1]</p>	F 686	<p>F686 All residents have the potential to be affected by this deficient practice.</p> <p>1. Resident #41 was immediately assessed and found to be [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1] were placed by the [US FOIA (b)(6)] on Resident #41 immediately. The [US FOIA (b)(6)] was educated by the DON/designee on 4/6/23 on [NJ Exec Order 26.4b1] proper administration of [NJ Exec Order 26.4b1] while in bed, and proper documentation on the TAR. [NJ Exec Order 26.4b1] was identified by the deficient practice.</p> <p>1a. All residents were audited, and their orders and care plans were updated. The DON/designee ensured that each one of the identified residents had appropriate individualized interventions in place for pressure injury prevention</p> <p>2. The DON/designee educated all licensed nurses and certified nursing assistants regarding pressure injury prevention measures, including the proper use of heel booties.</p> <p>2a. The DON/designee educated all nurses on proper documentation on the TAR.</p> <p>2b. The DON/designee educated all nurses to ensure that heel booties are properly applied prior to signing the TAR</p> <p>3. The facility will monitor corrective</p>		

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F 686	<p>Continued From page 44</p> <p>NJ Exec Order 26.4b1 [REDACTED]. The care plan was revised on NJ Exec Order 26.4b1 to indicate NJ Exec Order 26.4b1 were to be on R41's NJ Exec Order 26.4b1 [REDACTED].</p> <p>Review of R41's "Physician's Orders," located in the EMR under the "Orders" tab, revealed orders dated NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1.</p> <p>Review of R41's progress notes located in the EMR under the "Prog Notes" tab revealed NJ Exec Order 26.4b1 by R41 to NJ Exec Order 26.4b1.</p> <p>A document titled; NJ Exec Order 26.4b1 "Progress Notes," dated NJ Exec Order 26.4b1 and provided by Licensed Practical Nurse (LPN) 5 indicated R41 was to have NJ Exec Order 26.4b1 on at all times except during AM care.</p> <p>Observation on 04/03/23 at 10:03 AM in R41's room revealed R41 was lying in bed on NJ Exec Order 26.4b1 back with the NJ Exec Order 26.4b1. R41's NJ Exec Order 26.4b1 [REDACTED].</p> <p>An additional observation made on NJ Exec Order 26.4b1 at 8:45 AM in R41's room revealed R41 was lying in bed on NJ Exec Order 26.4b1 back with the NJ Exec Order 26.4b1. R41 was NJ Exec Order 26.4b1 [REDACTED].</p> <p>A final observation and concurrent interview on 04/06/23 at 9:40 AM in R41's room revealed R41</p>	F 686	<p>actions to ensure the deficient practice is being corrected and will not recur.</p> <p>3a The DON/designee will conduct random audits of all residents who use heel bottles or have their heels offloaded while in/out of bed</p> <p>3b. Random audits will be done weekly x 4 weeks then continue monthly x 2 months</p> <p>3c. All findings of the audits will be presented to the monthly QAPI committee for 3 months.</p>		

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F 686	Continued From page 45 was lying in bed with the NJ Exec Order 26.4b1 R41 was leaning to the right with the NJ Exec Order 26.4b1 resting on the flat sheet on the NJ Exec Order 26.4b1 . The NJ Exec Order 26.4b1 were observed on the counter in the room. Certified Nursing Assistant (CNA) 5, in the room at the time of the observation, verified that she had been responsible for R41's care over the last two days on the day shift and had not placed NJ Exec Order 26.4b1 on either day. Licensed Practical Nurse (LPN)5, also in R41's room at the time of the observation, stated R41 should always be NJ Exec Order 26.4b1 to prevent NJ Exec Order 26.4b1 . During an interview on 04/06/23 at 12:01 PM, the U.S. FOIA (b)(6) stated the NJ Exec Order 26.4b1 were to NJ Exec Order 26.4b1 as physician's orders specify. Review of the facility's policy titled "Pressure Ulcer Prevention," reviewed July 2018, provided by the facility, revealed "All residents with pressure ulcers will receive the appropriate treatment as prescribed by a physician. . . To promote optimum healing of pressure ulcers." NJAC 8:39-25.2(c) NJAC 8:39-27.1(e)	F 686			
F 689 SS=D	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		4/28/23	

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F 689	<p>Continued From page 46</p> <p>supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to provide adequate monitoring and supervision for 12 (Resident (R) 98, R36, R149, R159, R5, R99, R113, R32, R100, R102, R124, and R129) of 32 residents that required supervision per the NJ Exec Order 26.4b1 out of a total of 43 residents who NJ Exec Order 26.4b1. The facility further failed to assess one (R129) of 42 residents that NJ Exec Order 26.4b1. The facility failed to ensure a medication cart was locked during medication administration. The medication cart on the NJ Exec Order 26.4b1 wing remained unlocked for 15 minutes with NJ Exec Order 26.4b1 on top on the cart with staff members and residents passing by.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of R98's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed the resident was admitted to the facility on NJ Exec Order 26.4b1 with diagnoses of NJ Exec Order 26.4b1 <p>Review of R98's quarterly "Minimum Data Set (MDS)," located in the EMR under the "MDS" tab, with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b1, revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of NJ Exec Order 26.4b1, indicating R98 was NJ Exec Order 26.4b1</p>	F 689	<p>F689 All residents have the potential to be affected by this deficient practice.</p> <ol style="list-style-type: none"> The facility failed to provide adequate monitoring and supervision for Residents #98, #36, #149, #159, #5, #99, #113, #32, #100, #102, #124, and #129. Medication cart on NJ Exec Order 26.4b1 remained unlocked for 15 minutes with NJ Exec Order 26.4b1 on top of cart with residents and staff walking by. Resident #129 was NJ Exec Order 26.4b1. An audit was completed on all residents that smoke. All nurses were re-inserviced about locking the med cart and not leaving medication on top of the med cart An in-service was completed with nurses, CNAs, Activity aides/security on smoking/monitoring/supervising residents Smoking Policy was updated to include that staff will be outside with the residents, to supervise residents during smoking times. Forms were developed for both smoking and locking med cart/not leaving medication on top of med cart and initiated by the DON/designee and is being utilized bi-weekly to monitor/supervise residents during smoking sessions and staff during med 		

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F 689	<p>Continued From page 47</p> <p>Review of R98's "Care Plan," located in the EMR under the "Care Plan" tab, revealed "Resident is a [redacted] Interventions: Instruct resident about the facility policy on [redacted] locations, times, safety concerns."</p> <p>Review of R98's "NJ Exec Order 26.4b1," dated [redacted], located in the EMR under the "Assessments" tab, revealed the " IDTC [Interdisciplinary Team Committee] Decision - NJ Exec Order 26.4b1 ."</p> <p>2. Review of R36's "Admission Record," located in the EMR under the "Profile" tab, revealed the resident was admitted to the facility on [redacted] with diagnoses of NJ Exec Order 26.4b1 [redacted]</p> <p>Review of R36's quarterly "MDS," located in the EMR under the "MDS" tab, with an ARD of [redacted], revealed the resident had a "BIMS" score of [redacted], indicating R36 was NJ Exec Order 26.4b1 .</p> <p>Review of R36's "Care Plan," located in the EMR under the "Care Plan" tab, revealed "Resident is a [redacted] Interventions: Instruct resident about the facility policy on [redacted]: locations, times, safety concerns."</p> <p>Review of R36's "NJ Exec Order 26.4b1," dated [redacted], located in the EMR under the "Assessments" tab, revealed the " IDTC Decision - safe to NJ Exec Order 26.4b1 ."</p> <p>3. Review of R149's "Admission Record," located in the EMR under the "Profile" tab, revealed the</p>	F 689	<p>pass. The Activities Director will be responsible for ensuring the completion of the smoking form and DON/designee will be responsible for the med cart form. The results of the monitoring will be submitted monthly x 6 months to the QAPI committee.</p>		

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F 689	<p>Continued From page 48</p> <p>resident was admitted to the facility on [redacted] with diagnoses of [redacted] NJ Exec Order 26.4b1</p> <p>[redacted]</p> <p>Review of R149's quarterly "MDS," located in the EMR under the "MDS" tab, with an ARD of [redacted] NJ Exec Order 26.4b1, revealed the resident had a "BIMS" score of [redacted] NJ Exec Order 26.4b1, indicating R149 was [redacted] NJ Exec Order 26.4b1.</p> <p>Review of R149's "Care Plan," located in the EMR under the "Care Plan" tab, revealed "Resident is a [redacted] NJ Exec Order 26.4b1; Interventions: Instruct resident about the facility policy on [redacted] NJ Exec Order 26.4b1 locations, times, safety concerns."</p> <p>Review of R149's "NJ Exec Order 26.4b1," dated [redacted] NJ Exec Order 26.4b1 and located in the EMR under the "Assessments" tab, revealed the " IDTC Decision - safe to [redacted] NJ Exec Order 26.4b1."</p> <p>During an observation on 04/03/23 at 12:15 PM, R98, R36, and R149 were [redacted] NJ Exec Order 26.4b1 in the [redacted] NJ Exec Order 26.4b1. There were no staff observed outside at the time of this observation.</p> <p>During the interview on 04/03/23 at 12:18 PM, Certified Nursing Assistant (CNA) 4 stated that the Activities department was required to monitor the residents [redacted] NJ Exec Order 26.4b1. CNA4 confirmed there were no staff outside during this observation.</p> <p>4. Review of R159's "Admission Record," located in the EMR under the "Profile" tab, revealed the resident was admitted to the facility on [redacted] NJ Exec Order 26.4b1 with diagnoses of [redacted] NJ Exec Order 26.4b1</p>	F 689			

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F 689	<p>Continued From page 49</p> <p>NJ Exec Order 26.4b1).</p> <p>Review of R159's admission "MDS," located in the EMR under the "MDS" tab, with an ARD of NJ Exec Order 26.4b1, revealed the resident had a "BIMS" that was not assessed.</p> <p>Review of R159's "Care Plan," located in the EMR under the "Care Plan" tab, revealed the absence of a NJ Exec Order 26.4b1 care plan.</p> <p>Review of R159's NJ Exec Order 26.4b1 Screen," dated 02/27/23, located in the EMR under the "Assessments" tab, revealed the " IDTC Decision - safe to NJ Exec Order 26.4b1 ."</p> <p>During an observation on 04/04/23 at 9:05 AM, U.S. FOIA (b)(6)) 2 stood inside the doorway of the NJ Exec Order 26.4b1 room and handed NJ Exec Order 26.4b1 to residents as they went out to the NJ Exec Order 26.4b1. U.S. FOIA remained inside the facility while the residents were NJ Exec Order 26.4b1. There were NJ Exec Order 26.4b1 residents facing away from U.S. FOIA during this observation.</p> <p>During an interview on 04/06/23 at 6:54 PM, R159 stated that most of the time the staff stay on the inside of the building unless they come out to NJ Exec Order 26.4b1.</p> <p>5. Review of R5's "Admission Record," located in the EMR under the "Profile" tab, revealed the resident was admitted to the facility on NJ Exec Order 26.4b1 with diagnoses of NJ Exec Order 26.4b1.</p> <p>Review of R5's quarterly "MDS," located in the EMR under the "MDS" tab, with an ARD of NJ Exec Order 26.4b1, revealed the resident had a "BIMS" score of NJ Exec Order 26.4b1 indicating R5 was</p>	F 689			

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F 689	<p>Continued From page 50</p> <p>NJ Exec Order 26.4b1.</p> <p>Review of R5's "Care Plan," located in the EMR under the "Care Plan" tab, revealed "Is a NJ Exec Order 26.4b1 Interventions: The resident NJ Exec Order 26.4b1 NJ Exec Order 26.4b1."</p> <p>Review of R5's NJ Exec Order 26.4b1," dated NJ Exec Order 26.4b1 and located in the EMR under the "Assessments" tab, revealed the "IDTC Decision - safe to NJ Exec Order 26.4b1."</p> <p>6. Review of R99's "Admission Record," located in the EMR under the "Profile" tab, revealed the resident was admitted to the facility on NJ Exec Order 26.4b1 with diagnoses of NJ Exec Order 26.4b1.</p> <p>Review of R99's quarterly "MDS," located in the EMR under the "MDS" tab, with an ARD of NJ Exec Order 26.4b1, revealed the resident had a "BIMS" score of NJ Exec Order 26.4b1 indicating R99 was NJ Exec Order 26.4b1.</p> <p>Review of R99's "Care Plan," located in the EMR under the "Care Plan" tab, revealed "Resident is a NJ Exec Order 26.4b1 Interventions: Can NJ Exec Order 26.4b1 in NJ Exec Order 26.4b1 wing courtyard with activities during NJ Exec Order 26.4b1 times."</p> <p>Review of R99's NJ Exec Order 26.4b1 Screen," dated NJ Exec Order 26.4b1 and located in the EMR under the "Assessments" tab, revealed the "IDTC Decision - safe to NJ Exec Order 26.4b1."</p> <p>7. Review of R113's "Admission Record," located in the EMR under the "Profile" tab, revealed the resident was admitted to the facility on NJ Exec Order 26.4b1 with diagnoses of NJ Exec Order 26.4b1.</p>	F 689			

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F 689	<p>Continued From page 51</p> <p>Review of R113's annual "MDS," located in the EMR under the "MDS" tab with an ARD of [NJ Exec Order 26.4b1] revealed the resident had a "BIMS" score of [NJ Exec Order 26.4b1], indicating R113 was [NJ Exec Order 26.4b1].</p> <p>Review of R113's "Care Plan," located in the EMR under the "Care Plan" tab, revealed "Resident is a [NJ Exec Order 26.4b1]. Interventions: Make sure someone is directly [NJ Exec Order 26.4b1] while [NJ Exec Order 26.4b1] as [NJ Exec Order 26.4b1] in a couple of [NJ Exec Order 26.4b1]. The resident [NJ Exec Order 26.4b1] while [NJ Exec Order 26.4b1]."</p> <p>Review of R113's "[NJ Exec Order 26.4b1]," dated [NJ Exec Order 26.4b1], located in the EMR under the "Assessments" tab revealed the "IDTC Decision - safe to [NJ Exec Order 26.4b1]."</p> <p>During an observation and concurrent interview with the [U.S. FOIA (b)(6)] on 04/05/23 at 12:02 PM, R5, R36, R99, and R113 were [NJ Exec Order 26.4b1] in the courtyard. There were no staff observed outside [NJ Exec Order 26.4b1] the residents at the time of the observation. The [U.S. FOIA (b)(6)] and surveyor observed the residents through the activity department window, the [U.S. FOIA (b)(6)] stated that her assistant was supervising them from the other side of the [NJ Exec Order 26.4b1] unit door because of the [NJ Exec Order 26.4b1].</p> <p>8. Review of R32's "Admission Record," located in the EMR under the "Profile" tab, revealed the resident was admitted to the facility on [NJ Exec Order 26.4b1] with diagnoses of [NJ Exec Order 26.4b1].</p> <p>Review of R32's annual "MDS," located in the EMR under the "MDS" tab, with an ARD of</p>	F 689			

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F 689	<p>Continued From page 52</p> <p>NJ Exec Order 26.4b, revealed the resident had a "BIMS" score of NJ Exec Order 26.4b1, indicating R32 was NJ Exec Order 26.4b1.</p> <p>Review of R32's "Care Plan," located in the EMR under the "Care Plan" tab, revealed "Resident is a NJ Exec Order 26.4b Goals: The resident will not NJ Exec Order 26.4b1 without NJ Exec Order 26.4b1 through the review date."</p> <p>Review of R32's 'NJ Exec Order 26.4b1,' dated NJ Exec Order 26.4b, located in the EMR under the "Assessments" tab revealed the "IDTC Decision - safe to NJ Exec Order 26.4b1."</p> <p>9. Review of R100's "Admission Record," located in the EMR under the "Profile" tab revealed the resident was admitted to the facility on NJ Exec Order 26.4b with diagnoses of NJ Exec Order 26.4b1</p> <p>Review of R100's quarterly "MDS," located in the EMR under the "MDS" tab, with an ARD of NJ Exec Order 26.4b1 revealed the resident had a "BIMS" score of NJ Exec Order 26.4b1 indicating R100 was NJ Exec Order 26.4b1.</p> <p>Review of R100's "Care Plan," located in the EMR under the "Care Plan" tab revealed: "Resident is a NJ Exec Order 26.4b Goals: The resident will not NJ Exec Order 26.4b1 through the review date."</p> <p>Review of R100's 'NJ Exec Order 26.4b1,' dated NJ Exec Order 26.4b, located in the EMR under the "Assessments" tab, revealed the "IDTC Decision - safe to NJ Exec Order 26.4b1."</p> <p>10. Review of R102's "Admission Record," located in the EMR under the "Profile" tab,</p>	F 689			

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F 689	<p>Continued From page 53</p> <p>revealed the resident was admitted to the facility on [redacted] with diagnoses of [redacted].</p> <p>Review of R102's quarterly "MDS," located in the EMR under the "MDS" tab, with an ARD of [redacted], revealed the resident had a "BIMS" score of [redacted], indicating R102 was [redacted].</p> <p>Review of R102's "Care Plan," located in the EMR under the "Care Plan" tab, revealed "Resident is a [redacted] Interventions: The resident requires supervision while [redacted]."</p> <p>Review of R102's "NJ Exec Order 26.4b1," dated [redacted], located in the EMR under the "Assessments" tab, revealed the " IDTC Decision - safe to [redacted]."</p> <p>11. Review of R124's "Admission Record," located in the EMR under the "Profile" tab revealed the resident was admitted to the facility on [redacted] with diagnoses of [redacted].</p> <p>Review of R124's quarterly "MDS," located in the EMR under the "MDS" tab, with an ARD of [redacted], revealed the resident had a "BIMS" score of [redacted], indicating R124 was [redacted].</p> <p>Review of R124's "Care Plan," located in the EMR under the "Care Plan" tab, revealed "Resident is a [redacted] Interventions: The resident requires [redacted]."</p> <p>Review of R124's "NJ Exec Order 26.4b1," dated [redacted] located in the EMR under the</p>	F 689			

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F 689	<p>Continued From page 54</p> <p>"Assessments" tab, revealed the " IDTC Decision - safe to NJ Exec Order 26.4b1."</p> <p>12. Review of R129's "Admission Record," located in the EMR under the "Profile" tab, revealed the resident was admitted to the facility on NJ Exec Order 26.4b1 with diagnoses of NJ Exec Order 26.4b1</p> <p>Review of R129's annual "MDS," located in the EMR under the "MDS" tab, with an ARD of NJ Exec Order 26.4b1 revealed the resident had a "BIMS" score of NJ Exec Order 26.4b1, indicating R129 was NJ Exec Order 26.4b1.</p> <p>Review of R129's "Care Plan," located in the EMR under the "Care Plan" tab, revealed: "Resident is a NJ Exec Order 26.4b1 Goals: The resident will not NJ Exec Order 26.4b1 through the review date."</p> <p>Review of R129's complete EMR and paper record revealed the absence of a NJ Exec Order 26.4b1</p> <p>During an interview on 04/06/23 at 6:53 PM, R100 stated that dayshift staff let them (residents)] out the door and watched them through the door only coming out on rare occasions. R100 stated that the evening shift NJ Exec Order 26.4b1 let them (residents)out to NJ Exec Order 26.4b1 and they never come outside with them.</p> <p>During an interview on 04/06/23 at 10:03 AM, CNA 5 stated that the Activities department is responsible for supervising the residents during NJ Exec Order 26.4b1.</p> <p>An observation of resident NJ Exec Order 26.4b1 made on</p>	F 689			

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

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F 689	<p>Continued From page 55</p> <p>04/06/23 at 8:37 AM revealed seven residents in the designated courtyard [redacted] area without [redacted]. Two of the seven residents were out of view and three residents were facing away from [redacted] who was observed sitting in a chair on the inside of the building behind the door of the courtyard.</p> <p>During an interview with [redacted] on 04/06/23 at 8:45 AM, [redacted] stated she was allowed to sit on the inside of the building because of her [redacted]. When asked if all residents were in her line of sight, [redacted] stated, "No, I could not see all of them." [redacted] stated that the residents with their backs facing away from the door were not in full view.</p> <p>During an interview on 04/05/23 at 12:40 PM, LPN5 said that she is responsible for completing the [redacted] assessments and the expectation is for staff to be near the residents if they require [redacted].</p> <p>During an interview on 04/06/23 at 12:01 PM, [redacted] stated that the expectation is that staff must be outside with the residents during [redacted] to make sure the residents are not [redacted].</p> <p>During an interview on 04/05/23 2:15 PM, the [redacted] stated the employees must remain in constant vision and near the residents during [redacted], however he had not mandated that the employees be outside with the residents while they [redacted] because the staff members that do not [redacted] have may have a problem with the [redacted].</p> <p>Review of the facility's undated policy titled,</p>	F 689		

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F 689	<p>Continued From page 56</p> <p>"Smoking Policy," indicated, "Residents of Abigail House are permitted to smoke in the designated smoking area, with supervision at specified times."</p> <p>13. An observation of medication administration on 04/05/23 at 5:06 PM revealed Licensed Practical Nurse (LPN)7 setting up medications for R87 which included NJ Exec Order 26.4b1. After setting up the medications the nurse entered the resident's room leaving the medication cart unlocked with the NJ Exec Order 26.4b1 on top of the cart. The nurse gave the resident the NJ Exec Order 26.4b1 then went in the resident's bathroom to perform hand hygiene and don gloves to administer the resident's NJ Exec Order 26.4b1. At this time, the nurse was out of eyesight of her cart. While the nurse was in the room there were residents passing the hallway on their way to dinner and other staff members passing in the hallway by the unlocked medication cart. After the administering the NJ Exec Order 26.4b1, LPN7 entered the resident's bathroom again to remove her gloves and perform hand hygiene. Again, the unlocked medication cart was out of NJ Exec Order 26.4b1 of LPN7. The nurse returned to cart to get resident's NJ Exec Order 26.4b1 left on top of the cart and donned gloves to administer the second set of NJ Exec Order 26.4b1. At 5:14 PM the med cart remained unlocked, and LPN 7 moved onto the next resident's room.</p> <p>During an interview with LPN7 on 04/05/23 at 5:20 PM, LPN7 acknowledged that she had left the cart unlocked but she had positioned the cart in such a way that no one could tell the cart was unlocked and she felt that she could see the cart all the time that she was in the resident's room. The nurse was asked if she could see the cart</p>	F 689			

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F 689	Continued From page 57 while she was in the bathroom washing her hands and the nurse agreed that she could not see the cart and that she should not have left the eye drops on top of the cart. Interview with the LPN4 on 04/06/23 at 10:45 AM revealed it was an expectation for the nurses to lock the medication cart when not in use and not leave medications (including NJ Exec Order 26.4b1) on top of the cart. The medication cart when administering medications must be within the nurse's eyesight. Failure to do this posed a safety concern for the residents especially those NJ Exec Order 26.4b1 residents. Review of the facility policy titled "Medication Pass," with a review date of 07/2018, instructed the staff " Med cart must be visible to the nurse, or locked. The narcotic drawer must be locked Medications should never be left on top med cart."	F 689			
F 759 SS=E	NJAC 8:39-27.1(a) Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview and review of facility policy, the facility failed maintain a medication error rate below five percent. Out of 37 opportunities there were five errors/omissions occurred during medication	F 759	F759 All residents have the potential to be affected by this deficient practice	4/14/23	

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F 759	<p>Continued From page 58 administration on one [redacted] Wing) of [redacted] wings. The facility's medication error rate was 13.51%</p> <p>Findings include:</p> <p>Observation of medication passes throughout the facility on 04/04/23 and 04/05/23 revealed the following medication errors or omissions:</p> <p>1. On [redacted] Wing 04/05/23 at 4:37 PM revealed Registered Nurse (RN)1 setting up medications for R92.</p> <p>A review of R92's physician orders located in the electronic medical records (EMR) "Orders" tab documented the resident was to receive [redacted] NJ Exec Order 26.4b1</p> <p>The resident did not receive the [redacted] NJ Exec Order 26.4b1 during the medication observation.</p> <p>Interview on 04/05/23 at 5:40 PM, RN1 verified she did not give the [redacted] NJ Exec Order 26.4b1 during the medication pass because none was available in the resident's medication box.</p> <p>2. Observation on [redacted] Wing on 04/05/23 at 4:50 PM revealed RN1 performed a [redacted] NJ Exec Order 26.4b1 reading on R6. The [redacted] NJ Exec Order 26.4b1 reading was [redacted] NJ Exec Order 26.4b1 RN1 stated the reading was [redacted] NJ Exec Order 26.4b1 and according to the physician's orders the resident was on [redacted] NJ Exec Order 26.4b1. The resident was to receive [redacted] NJ Exec Order 26.4b1 of [redacted] NJ Exec Order 26.4b1 with the evening meal. And according to the [redacted] NJ Exec Order 26.4b1 the resident was to receive an additional [redacted] NJ Exec Order 26.4b1 of the [redacted] NJ Exec Order 26.4b1 which the resident would receive a total of [redacted] NJ Exec Order 26.4b1 of [redacted] NJ Exec Order 26.4b1. RN1 drew up [redacted] NJ Exec Order 26.4b1 of [redacted] NJ Exec Order 26.4b1</p>	F 759	<ol style="list-style-type: none"> Incident reports were created for Residents #92 and #6, [redacted] NJ Exec Order 26.4b1 were found Md notified, all medications given. Complete assessments done on both residents [redacted] NJ Exec Order 26.4b1 noted. Residents #92 & #6 were monitor for 72 hrs with no issues noted. Nurse suspended Nursing staff was in-serviced on the six rights of medication administration policy, and proper measurement of medications. ADON/IP, facility pharmacy consultant/designee will conduct medication pass audits monthly x 6 months. All results will be reported to QA monthly. 	

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F 759	<p>Continued From page 59</p> <p>NJ Exec Order 26.4b1 and placed it in the resident's NJ Exec</p> <p>Review of the resident's "physicians orders" in EMR located in the "Orders" tab revealed orders for NJ Exec Order 26.4b1 before meals for NJ Exec Order 26.4b1. Call the physician if NJ Exec is less than NJ Exec or over NJ Exec. For NJ Exec Order 26.4b1 the resident was to NJ Exec Order 26.4b1 before meals, hold if NJ Exec Order 26.4b1 is NJ Exec. Also, the resident was to receive NJ Exec Order 26.4b1</p> <p>The nurse administered an incorrect dosage of insulin and did not notify the physician of the resident elevated NJ Exec Order 26.4b1. The nurse did not administer the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 during the evening administration of medications.</p> <p>In an interview 04/06/23 at 10:45 AM the Licensed Practical Nurse (LPN) 4 stated resident was not on NJ Exec Order 26.4b1 for meals and according to MD's orders the resident should have received NJ Exec Order 26.4b1 units before the evening meal. LPN4 stated the resident received the wrong NJ Exec Order 26.4b1. LPN4 also stated the nurse should have given the NJ Exec Order 26.4b1</p> <p>A review of the facility policy titled "Medication Pass," with a review date of July 2018, stated, "All medications will be administered with physicians' orders and in a safe manner."</p>	F 759			

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F 759	Continued From page 60 NJAC 8:39-29.2(d)	F 759			
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of facility policy, the facility failed to ensure one resident (Resident (R) 6) of eight residents observed during medication administration received the NJ Exec Order 26.4b1 and dosage according physicians' orders. This failure has the potential for R6 to experience either NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 readings. Findings include: During medication pass on 04/05/23 at 4:50 PM Registered Nurse (RN)1 performed a NJ Exec Order 26.4b1 on R6. RN1 stated the reading was NJ Exec Order 26.4b1 and according to the physician's orders the resident was on NJ Exec Order 26.4b1 . The resident was to receive NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 with the evening meal. And according to the NJ Exec Order 26.4b1 the resident was to receive an additional NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 which R6 would receive a total NJ Exec Order 26.4b1 . RN1 drew up NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 and administered to R6's NJ Exec Order 26.4b1 Review of the resident's "Physicians Orders," located in the electronic medical record (EMR) "Orders" tab, revealed orders for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 before meals for	F 760	F760 All residents have the potential to be affected by this deficient practice 1. An incident report was created for Resident #6 with NJ Exec Order 26.4b1 noted. Nurse was suspended. 2. MD notified. 3. Resident monitored for 72 hours with NJ Exec Order 26.4b1 noted. 4. All nurses were in-serviced on proper medication administration on 4/7/23. 100% medication audit was completed. No further medication errors had occurred. 5. All nurses will have a 100% medication administration pass done by the pharmacy consultant, ADON, night supervisor and weekend supervisor and report to DON any deficiency. Any nurse with a deficiency will be removed from the schedule until they get a 100% medication pass rate.	4/24/23	

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F 760	<p>Continued From page 61</p> <p>NJ Exec Order 26.4b1. Call the physician if [redacted] is NJ Exec Order 26.4b1. For [redacted] coverage the resident was to receive [redacted].</p> <p>The nurse did not notify the physician of R6's abnormal [redacted].</p> <p>In an interview 04/06/23 at 10:45 AM the Licensed Practical Nurse (LPN) 4 stated resident was not on [redacted] for meals and according to MD's orders the resident should have received [redacted] before the evening meal. LPN4 stated the resident received the [redacted] coverage.</p> <p>Review of facility's undated policy titled "Insulin Administration" directed staff to "...Check the blood glucose per physician order or facility protocolCheck to order for the amount of insulin ordered."</p>	F 760	<p>6. Pharmacy consultant, ADON, weekend and night supervisor will conduct medication pass daily x one week, weekly x a month and monthly to report to QA monthly and report to QAPI quarterly.</p> <p>7. DON/designee will review 10 medication orders for 3x/weeks x 4 weeks, 25 medications orders weekly x 4 weeks, and then 25 medication orders monthly x 4 months.</p> <p>5. Will review audits monthly in QA and in QAPI quarterly.</p>		
F 812 SS=E	<p>NJAC 8:39-29.2(d) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements. The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent</p>	F 812		4/12/23	

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F 812	<p>Continued From page 62</p> <p>facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, the facility failed to provide food storage in a safe and consistent manner, for one of three [REDACTED] pantry refrigerators, and for one of one kitchen observed for food storage. This had the potential to affect 161 of 164 residents who consumed food from the kitchen, with possible foodborne illnesses related to the sanitation of food being stored and served.</p> <p>Findings include:</p> <p>During the initial tour of the main kitchen on 04/03/23 at 9:17 AM, accompanied by the [REDACTED] (US FOIA (b)(6)) revealed dry spices [seasoning salt and cumin] and open liquid condiments [soy sauce] that were not labeled with either a received or opened dates.</p> <p>During observations of the Unit [REDACTED] refrigerator on 04/06/23 at 11:12 AM, revealed the second clear plastic shelf was covered with a light orange liquid substance. The refrigerator had five bottles of water, two which were opened and labeled with initials, but with no dates on them. There was leftover food in a plastic reusable container with initials and no date on top.</p>	F 812	<p>F812 All residents have the potential to be affected by this deficient practice</p> <ol style="list-style-type: none"> 1. On 4/3/23 the spices were discarded by the Food Service Director 2. When a spice or herb is removed from the storage area to be used, it will be dated when it is opened for use. 3. To ensure that all the rules and regulations are being followed, opening and closing supervisor will check daily. 4. They will also be checked by the Food Service Director and/or the Assistant Food Service Director 5. They will be checked daily for 30 days, then check weekly for 4 weeks, and then monthly for one full year by the Food Service Director and/or the Assistant Food Service Director. This will also be a part of the quarterly Quality assurance report. 6. All refrigerators were immediately cleaned 		

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F 812	<p>Continued From page 63</p> <p>During an interview on 04/06/23, at 11:13 AM, Licensed Practical Nurse (LPN)1, said staff and resident items are kept in the Unit [REDACTED] refrigerator. She did not know who the items in the refrigerator belonged to, as there were only initials on the items. LPN1 did not know how long anything had been in the refrigerator.</p> <p>During an interview on 04/06/23, at 11:24 AM, the U.S. FOIA (b)(6) [REDACTED] said he was unaware that dietary staff were responsible for the resident refrigerators on the unit. The [REDACTED] confirmed the Unit [REDACTED] refrigerator was not clean, and the items were not marked properly.</p> <p>During an interview on 04/06/23, at 11:48 AM, the U.S. FOIA (b)(6) [REDACTED] stated that all kitchen and unit refrigerators for residents should be clean, and items properly marked.</p> <p>Review of the facility's undated policy titled "Food Storage" revealed " ...2. Plastic containers with tight fitting covers will be used for storing products such as grains, sugar, dried vegetables and broken lots of bulk foods. All containers must be legible and accurately labeled and dated."</p> <p>Review of the facility's undated policy titled "Food Brought in from Outside Sources and Personal Food Storage" revealed " ...</p> <p>5. Foods that are intended for later consumption, the designated staff will.</p> <p>a. Ensure the food is in a sealed container to prevent cross contamination.</p> <p>b. Label the food with the resident's name, room number and the date which the food was brought in.</p> <p>c. Determine if the food should be stored at room</p>	F 812	<p>7. All undated items in the refrigerators were immediately discarded.</p> <p>8. The Food Service Director continue to audit all refrigerators.</p> <p>9. The Administrator, DON, Food Service Director, and Unit Manager will audit 50% of the refrigerators 3 times weekly x 12 weeks to ensure open food and/or drinks are dated and are not expired, including spices. This audit will be documented on refrigerator audit tool.</p> <p>10. The monthly QI committee will review the results of the refrigerator audit tool for 3 months.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 812	Continued From page 64 temperature or under refrigeration. 6. Foods that require refrigeration/freezing: a. Ensure the food is in a sealed container to prevent cross contamination. b. Label the food with the resident's name, room number and the date which the food was brought in. c. Must be stored in a refrigerator outside of the food service department ...on the nursing unit or in personal refrigerators in the resident's room. d. Food will be held in the refrigerator for three (3) days following the date on the label and will be discarded by staff upon notification to resident.	F 812			
F 842 SS=E	NJAC 8:39-17.2(g) NJAC 8:39-19.7(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;	F 842		5/11/23	

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F 842	<p>Continued From page 65</p> <p>(iii) Readily accessible; and</p> <p>(iv) Systematically organized</p> <p>§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-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(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.</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services</p>	F 842			

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F 842	<p>Continued From page 66 provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review, and policy review, the facility failed to ensure that an admission record was completed for three residents (Resident (R)18, R137, and R141) in a total sample of 47 residents.</p> <p>Findings include:</p> <p>1. Review of R18's "5 day" scheduled "Minimum Data Set (MDS)," located in the electronic medical record (EMR) under the "MDS" tab, with an Assessment Reference Date (ARD) of [redacted], revealed R18 was originally admitted to the facility on [redacted] and re-admitted to the facility on [redacted] with a "Brief Interview for Mental Status (BIMS)" score of [redacted] indicating [redacted].</p> <p>2. Review of R137's quarterly "MDS" located in the EMR under the "MDS" tab, with an ARD of [redacted], revealed R137 was admitted to the facility on [redacted] with a "BIMS" score of [redacted], indicating [redacted].</p> <p>3. Review of R141's quarterly "MDS" located in the EMR under the "MDS" tab, with an ARD of [redacted] revealed R141 was admitted to the facility on [redacted] with a "BIMS" score of [redacted] indicating [redacted].</p>	F 842	<p>F842 All residents have the potential to be affected by this deficient practice</p> <p>The facility failed to ensure that an admission record was completed for 3 residents (Resident #18, #137, and # 141 in a total sample of 47 residents.</p> <p>1. An audit was completed by Social Services on all residents</p> <p>2. Admissions, business office manager and Social workers collaborated with resident #18, #137 and #141 and their families to create an admission package for these residents.</p> <p>3. Admission's Director will immediately notify Social Services if a resident is unable to sign for him/herself. Social Services will create a form to assist the resident and family to sign.</p> <p>4. Administrator/designee will monitor the audit daily x 2 weeks and weekly x 2 months, monthly for 2 months, reported monthly to QAPI committee, and quarterly at QA meeting.</p>		

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F 842	<p>Continued From page 67</p> <p>During an interview with the US FOIA (b)(6) on 04/04/23 at 5:30 PM, she stated there was no admission packet for R18 and had no further explanation for not having it.</p> <p>During an interview on 04/06/23 at 9:44 AM with the U.S. FOIA (b)(6) a request was made for the admission agreements for R18, R137, and R141. The U.S. FOIA (b)(6) stated no admission records existed for those residents. The U.S. FOIA (b)(6) stated the facility's practice was that whenever a resident was unable to sign admission paperwork, and had no representative with them, there would be a statement on the folder of the resident's business file.</p> <p>Review of the inside flap of R137's business folder provided by the U.S. FOIA (b)(6) revealed a handwritten statement dated NJ Exec Order 26.4b1 as follows: NJ Exec Order 26.4b1. No contact/phone numbers. All numbers we have on file are incorrect."</p> <p>Review of the inside flap of R141's business folder provided by the U.S. FOIA (b)(6) revealed a handwritten statement dated NJ Exec Order 26.4b1 as follows: NJ Exec Order 26.4b1."</p> <p>During an interview with the U.S. FOIA (b)(6) on 04/06/2023 at 12:22 PM, she stated R137 was NJ Exec Order 26.4b1 when NJ ER arrived at the facility and unable to sign any paperwork." When asked why an agreement packet was not created for residents who are unable to sign with notation that it had been presented to the resident who was unable to sign, the SSD2 stated it would be a "waste of paper."</p>	F 842			

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F 842	Continued From page 68 Review of the facility's policy titled "MEDICAL RECORDS POLICIES AND PROCEDURES POLICY," reviewed 07/2018, revealed: " ...A separate medical record shall be maintained for each resident admitted to the facility and the resident's name will be placed on all medical record forms. All physicians, nursing staff and other health care professionals involved in the resident's care will be responsible for making prompt, appropriate entries in the record and authenticating them with date, signature, and title. OBJECTIVE: To provide complete and accurate resident information for continuity of care. PROCEDURES...The resident's medical record shall contain at least the following information: ...Appropriate consent forms for treatment are signed by the resident or legal representative and entered in the medical record by admission office staff."	F 842			
F 847 SS=E	NJAC 8:39-35.2(d) Entering into Binding Arbitration Agreements CFR(s): 483.70(n)(2)(i)(ii)(3)-(5) §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of	F 847		5/1/23	

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F 847	<p>Continued From page 69</p> <p>his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility.</p> <p>§483.70(n)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement;</p> <p>§483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.</p> <p>§483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility.</p> <p>§483.70(n) (5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and policy review, the facility failed to ensure that binding</p>	F 847			
			F847		

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F 847	<p>Continued From page 70</p> <p>arbitration agreements were explained in a form and manner that residents understood, and failed to inform the resident that they had the right to rescind the agreement within 30 days of signing, for three residents (Resident (R)101, R103, and R152) of three residents reviewed for binding arbitration agreements out of a total sample of 47 residents</p> <p>Findings include:</p> <p>1. Review of R101's quarterly "Minimum Data Set (MDS)," located in the electronic medical record (EMR) under the "MDS" tab, with an Assessment Reference Date (ARD) of [redacted] revealed R101 was admitted to the facility on [redacted] with diagnoses that include NJ Exec Order 26.4b1 and had a "Brief Interview for Mental Status (BIMS)" score of [redacted] indicating [redacted]</p> <p>2. Review of R103's quarterly "MDS", located in the electronic medical record (EMR) under the "MDS" tab, with an ARD of [redacted], revealed R103 was admitted to the facility on [redacted] with diagnoses that included NJ Exec Order 26.4b1. [redacted] had a "BIMS" score of [redacted], indicating he was NJ Exec Order 26.4b1.</p> <p>3. Review of R152's quarterly "MDS", located in the EMR under the "MDS" tab, with an ARD of [redacted] revealed R152 was admitted to the facility on [redacted] with diagnoses that included NJ Exec Order 26.4b1. [redacted] had a "BIMS" score [redacted] indicating [redacted]</p> <p>Review of binding arbitration agreements</p>	F 847	<p>All residents have the potential to be affected by this deficient practice</p> <p>1. The facility has chosen to no longer ask residents or representative to sign a binding arbitration agreement</p> <p>2. All residents have the potential to be affected by this practice</p> <p>3. The US FOIA (b)(6) [redacted] have been in-serviced that we are no longer asking parties to sign binding arbitration agreements. Admissions Director/Social Worker will reach out to residents/representatives to inform them that the facility has resolved to not enforce it's right to bring disputes between parties to arbitration under the arbitration agreement signed by the parties</p> <p>4. Admissions Director/Social Worker will report to the QA committee next quarter that all residents/representative have been notified that the signed binding arbitration is no longer enforceable.</p>		

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F 847	<p>Continued From page 71</p> <p>provided by the facility revealed R101 had signed a binding arbitration on [redacted] R103 signed a binding arbitration agreement on [redacted]. R152 signed a binding arbitration agreement on [redacted] with the current [redacted] witnessing the signing.</p> <p>During an interview with R101 on 04/06/23 at 4:37 PM, R101 stated [redacted] signed a lot of papers upon admission [redacted]. When asked if [redacted] knew what a binding arbitration agreement was, [redacted] stated "they [the staff] would go over it." R101 stated [redacted] could [redacted] and could provide no further responses.</p> <p>During the survey, R103 was unavailable for interview.</p> <p>During an interview on 04/06/23 at 4:42 PM, R152 was [redacted] about whether [redacted] had signed a binding arbitration agreement.</p> <p>During an interview with the [redacted] on 04/06/23 at 10:00 AM she stated her assistant was the one who explained binding arbitration agreements to the residents before they signed.</p> <p>During an interview with the [redacted] on [redacted] she stated she had not fully read the arbitration agreement when she first started to explain it to residents. [redacted] stated that after reading the agreement, she would tell residents, "If you need to pursue a lawsuit against the facility then you waive your rights if you sign the paperwork." [redacted] admitted she did not understand</p>	F 847			

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F 847	<p>Continued From page 72</p> <p>the contents of the facility's binding arbitration agreement. When asked how she could explain the contents to a resident and elicit their understanding, she admitted that she could not ensure residents understood what they were signing, yet she obtained their signature stating they understood they were giving up their right to sue the facility.</p> <p>Review of the "Binding Arbitration Agreement" provided by the facility, revealed as follows:</p> <p>"...8. Miscellaneous... (2) this Agreement may be rescinded by written notice to the Facility from the Resident within 10 days of signature. If alleged acts underlying a dispute governed by the Agreement are committed prior to the rescission date, this Agreement shall be binding with respect to such alleged acts. If not rescinded within 10 days, this Agreement shall remain in effect for all care and services subsequently rendered at the Facility, even if such care and services are rendered following the Resident's discharge and readmission to the Facility."</p> <p>Review of the undated and untitled policy provided by the facility revealed:</p> <p>"It is the policy of the facility not to participate in any form of arbitration between the facility and the resident, resident representative. Procedure: the facility will not initiate or require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at the facility."</p> <p>During an interview with the U.S. FOIA (b)(6)</p>	F 847			

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F 847	Continued From page 73 U.S. FOIA (b)(6) she stated that she had retrieved the above policy from an old policy book and did not know what a binding arbitration was.	F 847			
F 867 SS=E	NJAC 8:39-4.1(a)8 QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such	F 867		4/12/23	

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F 867	<p>Continued From page 74 development, monitoring, and evaluation.</p> <p>§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.</p> <p>§483.75(d) Program systematic analysis and systemic action.</p> <p>§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.</p> <p>§483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.</p> <p>§483.75(e) Program activities.</p> <p>§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity</p>	F 867			

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

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F 867	<p>Continued From page 75 of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.</p> <p>§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.</p> <p>§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.</p> <p>§483.75(g) Quality assessment and assurance.</p> <p>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:</p> <p>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including</p>	F 867			

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F 867	<p>Continued From page 76</p> <p>data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and review of facility documentation, the Quality Assurance (QA) committee failed to identify and take corrective action related to the following quality deficiencies:</p> <ol style="list-style-type: none"> 1. sanitizing multi-use glucometers before and after each resident; 2. binding arbitration agreements; 3. surety bond; and 4. medication administration errors. <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility staff failed to sanitize multi -use glucometers before and after each resident increasing the risk of transmission of blood borne pathogens to residents undergoing blood sugar checks. Cross reference: F880-K Infection Control. 2. The facility failed to ensure residents understood the binding arbitration agreements prior to signing and failed to ensure residents were given a choice of a neutral arbitrator and the option to rescind the agreement within 30 days of signing. Cross reference: F847-E Entering into Binding Arbitration Agreements and F848-E Binding Arbitration Agreements. 3. The facility failed to ensure that the facility's surety bond covered all the residents in the facility. Cross reference: F570-F Surety Bond Protection of Personal Funds. 4. The facility failed to ensure that the facility was free of a medication administration error rate of 	F 867	<p>F867</p> <p>All residents have the potential to be affected by this deficient practice</p> <ol style="list-style-type: none"> 1. QA committee failed to identify and take corrective actions related to the following quality deficiencies: <ul style="list-style-type: none"> #1- Sanitizing multi use glucometers before and after each resident #2 - Biding arbitration agreement #3 -Surety Bond #4 - Medication Administration Record <p>Qa committe met on 4/11/23 to review the purpose and function of the QAPI committee and review on-going compliance issues. The DON/ADON, MDS Coordinator, Nurse, Food Service Director, Maintenance Director, Social Workers, Admissions Director, and Housekeeping Manager will attend QAPI meetings on an ongoing basis and will assign additional team members as appropriate. The DON provided updates regarding POC to the Medical Director on 4/11/23.</p> <ol style="list-style-type: none"> 2. The QAPI Committee will begin to identify other areas of quality concern through the QI review process, for example; to review glucometer sanitization, surety bond, medication administration, review of resident council 		

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F 867	Continued From page 77 5% or more. Cross reference: F759-D Free from Medication Error Rates of 5% or More. During an interview on 04/06/23 at 6:14 PM, U.S. FOIA (b)(6) stated the facility was working on several performance improvement projects, none of which included the identified deficient practices. Review of a document provided by the facility titled "Quality Assurance/Quality Improvement," reviewed 07/2018, indicated ". . . The facility develops and maintains an active, continuous quality assurance/quality improvement process that involves staff, residents, and families... 4. The program shall identify problems in the care and services provided to all residents. 5. The quality assurance committee will monitor measures or indicators that lead to improved outcomes in care, operational and financial performance, and objective data to support claims of quality . . ." NJAC 8:39-33.2(a)	F 867	minutes, review of resident concern logs, review of pharmacy reports, and review of audits related to the plan of correction. 3. The QAPI committee will meet monthly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. 4. The QA committee will continue to meet quarterly, and QAPI committee monthly for one year with oversight by the Administrator/designee 5. The QAPI committee, including the Medical Director, will review quarterly compiled QAPI report information, review trends, and review corrective actions taken and the dates of completion. The QAPI committee will validate the facility's progress in correction of deficient practices or identify concerns. The Administrator will be responsible for ensuring QAPI committee concerns are addressed through further training or other interventions		
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		5/10/23	

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F 880	Continued From page 78 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (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	F 880			

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F 880	<p>Continued From page 79</p> <p>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.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to: a. sanitize NJ Exec Order 26.4b1 between uses for 10 (Resident (R)54, R92, R25, R110, R143, R13, R133, R139, R30, and R152) of 10 residents observed receiving NJ Exec Order 26.4b1) out of a total sample of 47 residents; b. perform hand hygiene and or wear gloves during NJ Exec Order for two residents (R61 and R150).</p> <p>The failure to sanitize glucometers between residents resulted in an Immediate Jeopardy (IJ) at F880-K: Infection Control due to the increased likelihood to cause serious harm due to the potential of cross-contamination of blood-borne pathogens.</p> <p>On 04/04/23 at 7:43 PM, the U.S. FOIA (b)(6)</p>	F 880	<p>F880</p> <p>Problem: The licensed staff person did not consider standard precautions. Person Issue Why: I did not think about the steps that were necessary to follow for infection control Why: I just started my medication pass and was not keeping with standard precautions. Why: I know it's important, I lost sight of protecting the resident from infections. I forgot. Why: I wanted to finish my medication pass. Why: Did not think it was an infection control concern. Problem to be solved:</p>		

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F 880	<p>Continued From page 80</p> <p>U.S. FOIA (b)(6) were notified of the Immediate Jeopardy (IJ) at F880-K Infection Control related to U.S. FOIA (b)(6) between each resident including residents identified with NJ Exec Order 26.4b1 concerns.</p> <p>The facility submitted an acceptable removal plan on U.S. FOIA (b)(6)</p> <p>The removal plan included educating the U.S. FOIA (b)(6) on system management and education of staff, sanitizing all glucometers, retraining, and ensuring competency of all U.S. FOIA (b)(6) on the use and sanitization of NJ Exec Order 26.4b1 securing NJ Exec Order 26.4b1 screenings for all residents receiving NJ Exec Order 26.4b1, and updating the policy on NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 sanitization to include using a manufacturer's approved sanitizing method.</p> <p>Through interviews with facility staff, observations of NJ Exec Order 26.4b1 tests, review of staff in-services and facility policy, the survey team verified all elements of the facility's IJ Removal Plan and therefore removed the IJ, effective 04/06/23 at 10:39 AM.</p> <p>The deficient practice remained at an "E" (pattern of potential for more than minimal harm) scope and severity following the removal of the immediate jeopardy.</p> <p>Findings include:</p> <p>a. The facility failed to sanitize glucometers according to manufacturer's instructions.</p>	F 880	<p>1 U.S. FOIA (b)(6) received educated importance of following standard precautions.</p> <p>2. Licensed staff know bloodborne pathogens and how they are transmitted. Identify Infection Prevention Category: The licensed staff person did not consider standard precautions. Person Issue Why: I did not think about the steps that were necessary to follow for infection control Why: I just started my medication pass and was not keeping with standard precautions. Why: I know it's important, I lost sight of protecting the resident from infections. I forgot. Why: I wanted to finish my medication pass. Why: Did not think it was an infection control concern.</p> <p>1 U.S. FOIA (b)(6) received educated importance of following standard precautions.</p> <p>2. Licensed staff know bloodborne pathogens and how they are transmitted. Identify Infection Prevention Category: Prevent the transmission of infections. What do we want to accomplish: 1. 100% licensed staff will be in-service on getting back to basics with maintaining standard precautions when delivering resident care</p> <p>2. Educate the licensed staff on bloodborne pathogens and the principles</p>		

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F 880	<p>Continued From page 81</p> <p>1. Review of R54's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R54 had diagnoses that included NJ Exec Order 26.4b1.</p> <p>2. Review of R92's "Admission Record," located under the "Profile" tab of the EMR, revealed R92 had diagnoses that included NJ Exec Order 26.4b1.</p> <p>3. Review of R25's "Admission Record," located under the "Profile" tab of the EMR, revealed R25 had diagnoses that included NJ Exec Order 26.4b1.</p> <p>4. Review of R110's "Admission Record," located under the "Profile" tab of the EMR, revealed R110 had diagnoses that NJ Exec Order 26.4b1.</p> <p>5. Review of R143's "Admission Record," located under the "Profile" tab of the EMR, revealed R143 had diagnoses that NJ Exec Order 26.4b1.</p> <p>Observation on 04/04/23 at 11:02 AM revealed Licensed Practical Nurse (LPN)6 performed hand hygiene and donned gloves to obtain a NJ Exec Order 26.4b1 on R110. The nurse did not clean or sanitize the NJ Exec Order 26.4b1 after she removed it from the medication cart. Once LPN6 performed the NJ Exec Order 26.4b1 she wiped the NJ Exec Order 26.4b1 with an alcohol wipe and placed it back in the cart.</p> <p>On 04/04/23 at 11:13 AM LPN 6 next used the NJ Exec Order 26.4b1 on R92 who has a diagnosis of NJ Exec Order 26.4b1. The nurse removed the NJ Exec Order 26.4b1 from the medication cart and performed hand hygiene but did not sanitize the NJ Exec Order 26.4b1 LPN6 obtained the NJ Exec Order 26.4b1 reading and removed</p>	F 880	<p>of Standard Precautions.</p> <p>What changes to be made will result in improvement:</p> <ol style="list-style-type: none"> Licensed staff will be knowledgeable on Standard Precautions and transmission of Bloodborne Pathogens Licensed staff will be given a quiz annually and on hire Staff at a glance Informational Board Standard Precautions Hand Hygiene, proper use of gloves Unit Manager/Supervisor will observe the licensed staff providing direct care and in keeping standard precautions. Administrative Staff. <p>Problem: Staff person failed to clean the NJ Exec Order 26.4b1 before and after each resident use.</p> <p>Person Issue Why: I was trying to get the resident <input type="checkbox"/> done NJ Exec Order 26.4b1 Why: I thought I only had to clean the NJ Exec Order 26.4b1 after I used it. Why: I did know I had to clean before use was necessary. Why: I was very NJ Exec Order 26.4b1 because the surveyor was on the unit. Why: Did not think it was an infection control concern. Problem to be solved: Licensed staff person received educated on the importance of cleaning resident medical equipment before and after every</p>		

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F 880	<p>Continued From page 82</p> <p>her gloves. The nurse placed the [NJ Exec Order 26.4b1] in her uniform jacket pocket. When the nurse returned to the medication cart, she removed the [NJ Exec Order 26.4b1] from her pocket and wiped it with an alcohol wipe and placed the [NJ Exec Order 26.4b1] in the medication cart drawer.</p> <p>Observation on 04/04/23 at 11:42 AM LPN6 removed the [NJ Exec Order 26.4b1] from the medication cart drawer to obtain a [NJ Exec Order 26.4b1] reading on R146. The nurse performed hand hygiene and donned gloves; however, she did not clean or sanitize the [NJ Exec Order 26.4b1]. After obtaining the resident's [NJ Exec Order 26.4b1] reading the nurse put the [NJ Exec Order 26.4b1] in her jacket pocket, performed hand hygiene and returned to the medication cart. The nurse put the [U.S. FOIA (b)(6)] in the medication cart without cleaning or sanitizing the unit. The nurse was asked if she had used the [NJ Exec Order 26.4b1] since she used it on R92 and she stated no. LPN6 stated that she uses alcohol wipes to clean the [NJ Exec Order 26.4b1] and the [NJ Exec Order 26.4b1]-Cloth germicidal wipes are to clean spills and the medication cart. During the interview, the nurse opened the container of [NJ Exec Order 26.4b1] wipes and started wiping down her medication cart.</p> <p>An additional interview with LPN6 on 04/04/23 at 2:11 PM revealed she uses the [NJ Exec Order 26.4b1]-wipes to wipe down the [U.S. FOIA (b)(6)] before the start of her shift, and in between each resident. However, the nurse admitted today she used alcohol wipes on the [NJ Exec Order 26.4b1] after testing R92, R110, and R146. LPN6 also stated she was not aware of R92's diagnosis of [NJ Exec Order 26.4b1].</p> <p>On 04/04/23 at 11:21 AM, Registered Nurse (RN) 2 was observed to remove a [NJ Exec Order 26.4b1] from the medication cart to perform a [NJ Exec Order 26.4b1]</p>	F 880	<p>resident use.</p> <p>Education on prevention steps necessary to care for residents. Also, time management discussed with emphasis on infection prevention. Identify infection Prevention category: Prevent the transmission of infections.</p> <p>What do we want to accomplish:</p> <p>100% licensed staff on Observation will be in compliance with following the facility's policy on cleaning the resident's glucometer before and after every use.</p> <p>What changes to be made will result in improvement:</p> <p>1. Licensed staff will receive education on the facility's Bedside Glucose monitoring policy and procedure.</p> <p>2. All licensed staff will have a competency on safe use of glucometer. Glucometer competencies will continue with all new hires, annually and as needed.</p> <p>3 Unit Manager/Supervisor will monitor daily when rounding during times of FSBS the license staff compliance on each shift. Who will be Responsible: Administrative Staff Licensed Nurse-IP Staff person Failed to wash hands before and after completing the FSBS. Person Issue</p>		

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F 880	<p>Continued From page 83 reading on R54, who has a diagnosis [redacted] LPN2 did not clean or sanitize the [redacted] and entered the resident's room and obtained a [redacted] reading. After obtaining the [redacted] LPN2 returned the [redacted] to the medication cart without cleaning or sanitizing it at all.</p> <p>Continuing observation on 04/05/23 at 11:21 AM, RN2 then moved to R25's room and prepared to obtain a [redacted] on R25. RN2 removed the same [redacted] from the cart without cleaning or sanitizing the unit. RN2 obtained the [redacted] from R25 and returned the unit to the medication cart without cleaning or sanitizing the unit at all.</p> <p>During an interview on 04/04/23 at 2:05 PM with RN2, he stated that used the [redacted] wipes before and after each resident uses the [redacted] RN2 was asked to show the container of [redacted] germicidal wipes that he used to clean the [redacted]. The nurse opened the cart and could not find the container of [redacted] wipes. RN2 went to the closet behind the nurses' station and brought a container of [redacted] wipes stating he used that container to clean the [redacted] LPN6 was also at the nurses' station listening to the interview. I was asked was that not the same container of [redacted] wipes that she had just opened, and she replied yes. RN 2 did not say anything else.</p> <p>6. Review of R13's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R13 had diagnoses that included [redacted]</p>	F 880	<p>Why: Staff person stated I know it, I was in a hurry Why: [redacted] about survey Why: Wanted everything to be done.</p> <p>Why: I just forgot. I know I have to wash my hands before performing [redacted] with a resident. Washing my hand or using hand sanitizer before going to resident [redacted] Problem to be solved: Staff person failed to wash hands before and after completing the [redacted] Person Issue</p> <p>Why: Staff person stated I know it, I was in a hurry Why: [redacted] about survey Why: Wanted everything to be done.</p> <p>Why: I just forgot. I know I have to wash my hands before performing [redacted] with a resident. Washing my hand or using hand sanitizer before going to resident [redacted] Individual education with this staff person Importance of following infection prevention <input type="checkbox"/> hand washing/ hand hygiene protocol, Stop the spread of infection to other residents and staff. Nursing staff will be compliant with hand hygiene. 1. All staff educated on hand hygiene and the importance of being mindful of</p>	

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F 880	<p>Continued From page 84</p> <p>Review of R13's "Physician Order," dated [redacted] and located under the "Orders" tab of the EMR, revealed R13 was to receive a [redacted] NJ Exec Order 26.4b1.</p> <p>7. Review of R133's "Admission Record," located under the "Profile" tab of the EMR, revealed R133 had diagnoses that included [redacted] NJ Exec Order 26.4b1 [redacted].</p> <p>Review of R133's "Physician Order," dated [redacted] and located under the "Orders" tab of the EMR, revealed R133 was to receive a [redacted] NJ Exec Order [redacted].</p> <p>8. Review of R139's "Admission Record," located under the "Profile" tab of the EMR, revealed R139 had diagnoses that included [redacted] NJ Exec Order 26.4b1 [redacted].</p> <p>Review of R139's "Physician Order," dated [redacted] and located under the "Orders" tab of the EMR, revealed R139 was to receive a [redacted] NJ Exec Order [redacted].</p> <p>9. Review of R30's "Admission Record," located under the "Profile" tab of the EMR, revealed R30 had diagnoses that included [redacted] NJ Exec Order 26.4b1 [redacted].</p> <p>Review of R30's "Physician Order," dated [redacted] and located under the "Orders" tab of the EMR, revealed R30 was to receive a [redacted] NJ Exec Order [redacted].</p> <p>10. Review of R152's "Admission Record," located under the "Profile" tab of the EMR, revealed R152 had diagnoses that included [redacted] NJ Exec Order 26.4b1 [redacted].</p>	F 880	<p>prevention transmission of infections</p> <p>2. Unit Manager/ Supervisor or designee will frequently check staff adherence to hand hygiene especially following tasks.</p> <p>3. Nursing Administration will random check</p> <p>Audit tool developed for hand hygiene. DON Unit Manager/Supervisor or designee. Identify Infection prevention category: Staff person failed to clean the [redacted] NJ Exec Order 26.4b1 before and after each resident use. Person Issue Why: I was trying to get the resident [redacted] NJ Exec Order 26.4b1 done Why: I thought I only had to clean the [redacted] NJ Exec Order 26.4b1 after I used it. Why: I did know I had to clean before was necessary. Why: I was very [redacted] NJ Exec Order 26.4b1 because the surveyor was on the unit. Why: Did not think it was an infection control concern.</p> <p>Licensed staff person received educated on the importance of cleaning resident medical equipment before and after every resident use.</p> <p>Education on prevention steps necessary to care for residents. Also, time management discussed with emphasis on infection prevention What do we want to accomplish: 100% licensed staff on Observation will be</p>		

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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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F 880	<p>Continued From page 85</p> <p>Review of R152's "Physician Order," dated [redacted] and located under the "Orders" tab of the EMR, revealed R152 was to receive a [redacted]</p> <p>Observation on 04/04/23 at 4:07 PM revealed Licensed Practical Nurse (LPN) 7 removing a basket of [redacted] testing supplies, including a [redacted] and alcohol wipes, from the top drawer of the medication cart used on the back portion of Hall [redacted]. LPN7 placed the basket of supplies on top of the medication cart.</p> <p>Continuing with the observation on 04/04/23 at 4:09 PM, LPN7 obtained the [redacted] from the basket and completed a [redacted] test for R13. LPN7 returned to the medication cart and placed the [redacted] on top of the medication cart. LPN7 did not sanitize the [redacted] appropriately prior to or after use.</p> <p>Continuing with the observation on 04/04/23 at 4:11 PM, LPN7 obtained the [redacted], wiped the [redacted] with an alcohol wipe, and completed a [redacted] test for R54. LPN7 returned to the medication cart, wiped the [redacted] with an alcohol wipe, and placed the [redacted] on top of the medication cart.</p> <p>Continuing with the observation on 04/04/23 at 4:15 PM, LPN7 obtained the [redacted], completed a [redacted] test for R133, returned to the medication cart, and placed the [redacted] on top of the medication cart. LPN7 did not sanitize the [redacted] appropriately prior to or after use.</p> <p>Continuing with the observation and a concurrent interview on 04/04/23 at 4:17 PM, LPN7 obtained the [redacted], wiped the [redacted] with an</p>	F 880	<p>in compliance with following the facility's policy on cleaning the resident's [redacted] before and after every use. What change to be made will result in improvement.</p> <p>1. Licensed staff will receive education on the facility's Bedside Glucose monitoring policy and procedure.</p> <p>2. All licensed staff will have a competency on safe use of glucometer. Glucometer competencies will continue with all new hires, annually and as needed.</p> <p>3 Unit Manager/Supervisor will monitor daily when rounding during times of FSBS the license staff compliance on each shift. Who will be responsible. Administrative Staff Licensed Nurse-IP Problem: Staff person performed a [redacted] omitted wearing gloves. Person Issue Why: Staff person stated I was rushing to complete. Why: I was not thinking Why: I just forgot it was necessary. Why: [redacted] about survey Why: Staff person Failed to wash hands before and after completing the [redacted] Person Issue</p> <p>Why: Staff person stated I know it, I was in a hurry.</p>		

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F 880	<p>Continued From page 86</p> <p>alcohol wipe and completed a [NJ Exec Order 26.4b1] test for R139. LPN7 returned to the medication cart, wiped the [NJ Exec Order 26.4b1] with an alcohol wipe, and placed the [NJ Exec Order 26.4b1] on top of the medication cart. LPN7 confirmed she was wiping the [NJ Exec Order 26.4b1] with an alcohol wipe. LPN7 did not sanitize the [NJ Exec Order 26.4b1] appropriately prior to or after use.</p> <p>Continuing with the observation on 04/04/23 at 4:22 PM, LPN7 7 obtained the [NJ Exec Order 26.4b1] and completed a [NJ Exec Order 26.4b1] test for R30. LPN7 returned to the medication cart, wiped the [NJ Exec Order 26.4b1] with an alcohol wipe, and placed the [NJ Exec Order 26.4b1] on top of the medication cart. LPN7 did not sanitize the [NJ Exec Order 26.4b1] appropriately prior to or after use.</p> <p>Continuing with the observation on 04/04/23 at 4:25 PM, LPN7 obtained the [NJ Exec Order 26.4b1], wiped the [NJ Exec Order 26.4b1] with an alcohol wipe, and completed a [NJ Exec Order 26.4b1] test for R152. LPN7 returned to the medication cart and placed the [NJ Exec Order 26.4b1] back in the basket with the other supplies. LPN7 did not sanitize the [NJ Exec Order 26.4b1] appropriately prior to or after use.</p> <p>During an observation and concurrent interview on 04/04/23 at 4:31 PM, LPN7 confirmed a container of "[NJ Exec Order 26.4b1]" sanitizing wipes was in the bottom left drawer of the medication cart.</p> <p>During an interview on 04/04/23 at 5:29 PM, the [NJ Exec Order 26.4b1] confirmed staff should be using sanitizing wipes, such as [NJ Exec Order 26.4b1] "wipes when sanitizing the [NJ Exec Order 26.4b1] and the [NJ Exec Order 26.4b1] should be sanitized between each use.</p>	F 880	<p>Why: [NJ Exec Order 26.4b1] about survey</p> <p>Why: Wanted everything to be done.</p> <p>Why: I just forgot. I know I have to wash my hands before performing [NJ Exec Order 26.4b1] with a resident. Washing my hand or using hand sanitizer before going to resident [NJ Exec Order 26.4b1]</p> <p>Staff person performed a [NJ Exec Order 26.4b1] omitted wearing gloves.</p> <p>Person Issue</p> <p>Why: Staff person stated I was rushing to complete.</p> <p>Why: I was not thinking</p> <p>Why: I just forgot it was necessary.</p> <p>Why: [NJ Exec Order 26.4b1] about survey</p> <p>Why:</p> <p>Staff person was re-educated on the prevention steps necessary to care for residents.</p> <p>Also, time management discussed with emphasis on infection prevention</p> <p>Prevent the transmission of infections.</p> <p>What do we want to accomplish:</p> <p>100% staff on Observation on resident care units will be re-educated on importance of following donning and duffing of gloves. Staff person Failed to wash hands before and after completing the [NJ Exec Order 26.4b1]</p> <p>Person Issue</p> <p>Why: Staff person stated I know it, I was in a</p>		

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F 880	<p>Continued From page 87</p> <p>During an interview on 04/05/23 at 3:19 PM, LPN7 stated she had used alcohol wipes to clean the [redacted] because that is what she thought they were supposed to do.</p> <p>An interview with the [redacted] 04/04/23 at 5:29 PM revealed she was not aware of any problems with staff not cleaning and sanitizing the [redacted] before and after each resident's use. [redacted] nurse joined the interview and was surprised at the observations. Both [redacted] U.S. FOIA (b)(6) stated the [redacted] U.S. FOIA (b)(6) last rounds in [redacted] and that he did not identify any problems; however, he did recommend training for nurses on cleaning and sanitizing the [redacted]. The [redacted] U.S. FOIA (b)(6) provided an In-service sheet dated 12/19/22 and 12/21/22 in which she discussed how to clean and sanitize the [redacted] "Monitoring Unit" according to manufacturer's instructions Neither [redacted] nor the [redacted] could explain what monitoring system was in place to ensure the staff were following [redacted] disinfectant procedures as trained. Both staff members were aware that the facility had some residents with diagnoses of [redacted] But the issue of transmission of [redacted] NJ Exec Order 26.4b1 and the number of residents with the diagnosis had not been discussed in the QA/QAPI meetings.</p> <p>A list of residents diagnosed with [redacted] NJ Exec Order 26.4b1 was requested from the facility. A review of the list revealed the facility had [redacted] residents that required [redacted] NJ Exec Order 26.4b1 monitoring: [redacted] residents with [redacted] NJ Exec Order 26.4b1 and [redacted] residents with [redacted].</p> <p>On 04/05/23 at 9:48 AM an interview was held with the [redacted] U.S. FOIA (b)(6). The [redacted] U.S. FOIA (b)(6)</p>	F 880	<p>hurry.</p> <p>Why: [redacted] NJ Exec Order 26.4 about survey</p> <p>Why: Wanted everything to be done.</p> <p>Why: I just forgot. I know I have to wash my hands before performing [redacted] NJ Exec Order with a resident. Washing my hand or using hand sanitizer before going to resident [redacted] NJ Exec Order</p> <p>Individual education with this staff person</p> <p>Importance of following infection prevention <input type="checkbox"/> hand washing/ hand hygiene protocol Stop the spread of infection to other residents and staff Nursing staff will be compliant with hand hygiene.</p> <ol style="list-style-type: none"> 1. All staff educated on hand hygiene and the importance of being mindful of prevention transmission of infections 2. Unit Manager/ Supervisor or designee will frequently check staff adherence to hand hygiene especially following tasks. 3. Nursing Administration will random check <p>Audit tool developed for hand hygiene.DON Unit Manager/Supervisor or designee</p> <p>Staff person Failed to wash hands before and after completing the [redacted] NJ Exec Order 2 Person Issue</p>	

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F 880	<p>Continued From page 88</p> <p>was unaware of the numbers of residents residing in the facility with the diagnoses of [redacted] NJ Exec Order 26.4b1 It was explained to the U.S. FOIA (b)(6) that the failure to clean and sanitize the [redacted] after each resident's use had placed the facility in immediate jeopardy situation. The U.S. FOIA (b)(6) stated that he understood the concern and felt the [redacted] and ICP nurse should have been monitoring this situation. The U.S. FOIA (b)(6) also stated he was very concerned about this problem; it should never have happened.</p> <p>b. Nursing staff failed to wear gloves and/or perform hand hygiene while performing [redacted]</p> <p>1. Review of R61's "Admission Record," located under the "Profile" tab of the EMR revealed the resident was admitted to the facility on [redacted] with diagnoses that included [redacted] NJ Exec Order 26.4b1</p> <p>Review of R61's "Physician Order," dated [redacted] NJ Exec Order 26.4b1 and located under the "Orders" tab of the EMR, revealed R61 was to receive a [redacted]</p> <p>2. Review of R150's "Admission Record," located under the "Profile" tab of the EMR, revealed the resident was admitted to the facility on [redacted] with diagnoses that included [redacted] NJ Exec Order 26.4b1</p> <p>Review of R150's "Physician Order," dated [redacted] NJ Exec Order 26.4b1, indicated R15 was to receive a [redacted] NJ Exec Order</p>	F 880	<p>Why: Staff person stated I know it, I was in a hurry.</p> <p>Why: [redacted] NJ Exec Order 26.4 about survey</p> <p>Why: Wanted everything to be done.</p> <p>Why: I just forgot. I know I have to wash my hands before performing [redacted] NJ Exec Order with a resident. Washing my hand or using hand sanitizer before going to resident [redacted] NJ Exec Order</p> <p>Individual education with this staff person</p> <p>Importance of following infection prevention <input type="checkbox"/> hand washing/ hand hygiene protocol Stop the spread of infection to other residents and staff.</p> <p>Nursing staff will be compliant with hand hygiene.</p> <p>1. All staff educated on hand hygiene and the importance of being mindful of prevention transmission of infections</p> <p>2. Unit Manager/ Supervisor or designee will frequently check staff adherence to hand hygiene especially following tasks.</p> <p>3. Nursing Administration will random check</p> <p>Audit tool developed for hand hygiene. DON Unit Manager/Supervisor or designee</p>		

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F 880	<p>Continued From page 89</p> <p>During an observation on 04/04/23 at 4:02 PM, LPN3 performed NJ Exec Order 26.4b1 tests for Residents (R61 and R150). LPN3 retrieved the NJ Exec Order 26.4b1 from the top drawer of the medication cart. The surveyor observed two brown smears across the screen of the NJ Exec Order 26.4b1. LPN3 wiped the NJ Exec Order 26.4b1 with a NJ Exec Order 26.4b1 and placed the NJ Exec Order 26.4b1 directly onto the top of the medication cart. The NJ Exec Order 26.4b1 appeared dirty. When asked about the dirty appearance on the NJ Exec Order 26.4b1, LPN3 stated "Oh, that must be my NJ Exec Order 26.4b1 that's what that is." LPN3 proceeded to the dining room and located R61 at a table sitting with two other residents. LPN3 wiped R61's NJ Exec Order 26.4b1 with an alcohol swab, placed the used alcohol swab onto the dining room table, performed the NJ Exec Order 26.4b1 and placed the NJ Exec Order 26.4b1 directly onto the dining room table. LPN3 picked up the used alcohol swab from the table and used it to wipe R61's NJ Exec Order 26.4b1. LPN3 gathered all supplies into ungloved hands, proceeded back to medication cart, and placed all supplies onto the top of the cart. LPN3 obtained NJ Exec Order 26.4b1 out of the NJ Exec Order 26.4b1 bottle with ungloved hands, replaced the used NJ Exec Order 26.4b1 with an NJ Exec Order 26.4b1 and touched the NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 to transfer a NJ Exec Order 26.4b1. When asked the purpose of this, LPN3 stated, "sometimes it doesn't register, and you have to get a NJ Exec Order 26.4b1 get it to register." LPN3 removed the NJ Exec Order 26.4b1 from the NJ Exec Order 26.4b1 ungloved, discarded both strips and the used alcohol swab into the trash.</p> <p>Continuing with the observation on 04/04/23 at 4:07 PM, LPN3 retrieved a NJ Exec Order 26.4b1 and an alcohol swab from the top drawer of the medication cart, gathered all supplies with ungloved hands, and</p>	F 880	<p>1. Staff will be re-educated. Why Donning & Doffing gloves is important part of stopping the introduction of infections.</p> <p>2. Unit manager/Supervisor will monitor staff on rounds for staff compliance throughout the shifts to observe staff's compliance.</p> <p>Administrative Staff</p> <p>Who will be responsible: Administrative Staff, Don, Unit Manager/supervisor or designee.</p>		

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F 880	<p>Continued From page 90</p> <p>proceeded back to dining room. LPN3 located R150 sitting at a dining room table with three other residents. LPN3 wiped R150's [redacted] with an alcohol swab, placed the used alcohol swab onto the dining room table, performed the [redacted] test, and placed the [redacted] directly onto the dining room table. LPN3 picked up the used alcohol swab from the table and used it to wipe R150's [redacted]. LPN3 gathered all supplies with ungloved hands, proceeded back to medication cart, and placed all supplies onto the top of the cart. LPN3 obtained a [redacted] out of the [redacted] with [redacted] ungloved hands, replaced with [redacted] with the [redacted] and touched the [redacted] to the [redacted], stating, "this one didn't register either." LPN3 gathered both used [redacted] and alcohol swab with ungloved hands to discard into the trash. LPN3 wiped the [redacted] with a [redacted] placed it back into the top drawer of the medication cart and stated, "that's it." LPN3 walked over to sit at the nurse's station without performing any type of hand hygiene. LPN3 failed to perform hand hygiene or don gloves throughout the entire observation. LPN3 did not sanitize the [redacted] between resident tests.</p> <p>During an interview on 04/04/23 at 4:16 PM, when asked about donning gloves for [redacted] procedure, LPN3 stated, "Do you think I should be wearing gloves?" LPN3 was asked about the facility's policy on wearing gloves during [redacted] procedure and before LPN3 answered, the unit manager LPN5 stated, "yes, we're supposed to wear gloves." LPN3 stated she did not know she was supposed to wear gloves while performing a [redacted] test. LPN3 stated the facility policy was to wash hands before and after performing a [redacted]</p>	F 880			

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F 880	Continued From page 91 test. LPN3 stated she did not wash her hands before, after, or between performing [redacted] test on R61 and R150. LPN3 also stated that she failed to sanitize the [redacted] between resident usage. During an interview on 04/06/23 at 12:01 PM, the [redacted] stated the facility's policy on infection control practices during [redacted] tests was to sanitize the [redacted] with [redacted] before and after use. The [redacted] stated the nurses should don gloves for the procedure and should perform hand hygiene before and afterwards.	F 880			
F 919 SS=D	NJAC 8:39-19.4(a)(l) Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, the facility failed to ensure one (Resident (R) 68) of 47 sampled residents had a functioning call light system. Findings include:	F 919	F919 All residents have the potential to be affected by this deficient practice 1. Facility failed to ensure that Resident #68 had a functioning call system.	4/12/23	

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F 919	<p>Continued From page 92</p> <p>Review of R68's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed the resident was admitted to the facility on [redacted] with diagnoses of NJ Exec Order 26.4b1.</p> <p>Review of R68's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted], revealed the resident had a "Brief Interview for Mental Status (BIMS)" score that was not assessed due to [redacted].</p> <p>During an observation on 04/03/23 at 12:52 PM and 04/04/24 at 8:34 AM, R68's call light outlet was observed with no call light cord attached. There was no call light cord observed in the room.</p> <p>During a concurrent observation and interview on 04/05/23 at 12:30 PM, the [redacted] U.S. FOIA (b)(6) observed the call light outlet with the surveyor and confirmed the call light cord was not present in the room. The [redacted] stated that staff report environmental issues by writing them in a binder located at the nurses' station and he was unaware of R68's call light not functioning.</p> <p>During an interview on 04/06/23 at 9:44 AM, Licensed Practical Nurse (LPN) 5 stated that the issue with R68's call light had not been reported and she was unaware that the call light had been broken from the outlet. LPN5 explained that call light issues are reported to maintenance via the maintenance log that is located at the nurses' station.</p> <p>Review of an "Abigail House Maintenance Log," provided by LPN5, revealed no documentation</p>	F 919	<p>2. The call light not functioning in Resident #68s room was immediately fixed by the Maintenance Director. All staff was re-educated on the correct process for reporting when call lights are not functioning to the Maintenance Director so he can replace and/or fix call lights as indicated.</p> <p>3.A 100% audit of all call lights was completed by the Maintenance Director to ensure all call lights were functioning. No other call lights were identified to be broken and/or not functioning.</p> <p>4. The Administrator/Maintenance Director will audit all facility call lights once daily for 3 weeks and once weekly thereafter for 3 months to ensure all lights are functioning.</p> <p>5. The Administrator/Maintenance Director will present audit tools to the QA monthly and to the QAPI quarterly committee for review.</p>		

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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 04/11/2023
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 919	<p>Continued From page 93 that staff reported R68's nonfunctioning call light.</p> <p>During an interview on 04/06/23 at 12:01 PM, the U.S. FOIA (b)(6) stated she expected the call lights to be functioning and that the staff are to inform maintenance of any nonfunctional call lights.</p> <p>During an interview on 04/05/23 at 2:15 PM, the U.S. FOIA (b)(6) stated he expected the call lights to be available to all residents and to function properly.</p> <p>Review of the facility's policy titled, "Answering the Call Light," reviewed July 2018, indicated, "Be sure that the call light is plugged in at all times." This policy further indicated, "Report all defective call lights to the nurse supervisor promptly."</p> <p>NJAC 8:39-31.8(c)9</p>	F 919			

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 04/11/2023
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NAME OF PROVIDER OR SUPPLIER ABIGAIL HOUSE FOR NURSING & REHABILIT/	STREET ADDRESS, CITY, STATE, ZIP CODE 1105 -1115 LINDEN STREET CAMDEN, NJ 08102
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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes.	S 560	S560 1. All residents have the potential to be affected by a staff shortage. However no care issues were identified on the nine shifts we were found deficient. 2. The Staffing Coordinator was in-serviced regarding the tag S560 to ensure that the staffing requirements are met. Staffing agencies are being used to fill any shortages. Wage analysis were	5/3/23

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

TITLE

(X6) DATE

Electronically Signed

04/28/23

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 04/11/2023
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S 560	<p>Continued From page 1</p> <p>Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21.</p> <p>1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios:</p> <p>(1) one certified nurse aide to every eight residents for the day shift;</p> <p>(2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and</p> <p>(3) 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 and perform certified nurse aide duties</p> <p>b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census.</p> <p>c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place.</p> <p>(2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when</p>	S 560	<p>conducted with a recruit, hire, and retain staff plan, sign on and referral bonuses are in place along with overtime and weekend bonuses. The Administrator and Staff Coordinator meet weekly to review staffing schedules.</p> <p>3. All residents are at risk to be affected by the deficient practice.</p> <p>4. The facility will utilize internal and 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 staffing shortage.</p> <p>5. The facility will add an additional weekend bonus pay to ensure the weekends are staffed appropriately</p> <p>6. For the next month, the Administrator/designee will review the projected staffing hours daily to ensure staffing hours above state minimum.</p> <p>7. Findings will be submitted for 3 months to the monthly QAPI committee who will determine further inventions as needed.</p>	

New Jersey Department of Health

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NAME OF PROVIDER OR SUPPLIER ABIGAIL HOUSE FOR NURSING & REHABILIT/	STREET ADDRESS, CITY, STATE, ZIP CODE 1105 -1115 LINDEN STREET CAMDEN, NJ 08102
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S 560	<p>Continued From page 2</p> <p>the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.</p> <p>(3) All computations shall be based on the midnight census for the day in which the shift begins.</p> <p>d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ...</p> <p>A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 3/19/23 to 3/25/23, and 3/26/23 to 4/01/23, revealed the following</p> <p>The facility was deficient in CNA staffing for residents on 8 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows:</p> <ul style="list-style-type: none"> -03/19/23 had 15 CNAs for 166 residents on the day shift, required 21 CNAs. -03/20/23 had 20 CNAs for 165 residents on the day shift, required 21 CNAs. -03/22/23 had 16 CNAs for 165 residents on the day shift, required 21 CNAs. -03/24/23 had 19 CNAs for 164 residents on the day shift, required 20 CNAs. -03/25/23 had 18 CNAs for 164 residents on the day shift, required 20 CNAs. -03/26/23 had 14 CNAs for 164 residents on the day shift, required 20 CNAs. -03/26/23 had 10 total staff for 164 residents on the overnight shift, required 12 total 	S 560		
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New Jersey Department of Health

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S 560	Continued From page 3 staff. -03/27/23 had 18 CNAs for 164 residents on the day shift, required 20 CNAs. -04/01/23 had 18 CNAs for 163 residents on the day shift, required 20 CNAs.	S 560		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315267	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 6/6/2023	Y3
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 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 F0558 Reg. # 483.10(e)(3) LSC	Correction Completed 05/03/2023	ID Prefix F0565 Reg. # 483.10(f)(5)(i)-(iv)(6)(7) LSC	Correction Completed 04/26/2023	ID Prefix F0570 Reg. # 483.10(f)(10)(vi) LSC	Correction Completed 04/14/2023
ID Prefix F0574 Reg. # 483.10(g)(4)(i)-(vi) LSC	Correction Completed 04/12/2023	ID Prefix F0575 Reg. # 483.10(g)(5)(i)(ii) LSC	Correction Completed 04/19/2023	ID Prefix F0578 Reg. # 483.10(c)(6)(8)(g)(12)(i)-(v) LSC	Correction Completed 05/10/2023
ID Prefix F0585 Reg. # 483.10(j)(1)-(4) LSC	Correction Completed 04/12/2023	ID Prefix F0644 Reg. # 483.20(e)(1)(2) LSC	Correction Completed 05/23/2023	ID Prefix F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 05/24/2023
ID Prefix F0657 Reg. # 483.21(b)(2)(i)-(iii) LSC	Correction Completed 05/26/2023	ID Prefix F0677 Reg. # 483.24(a)(2) LSC	Correction Completed 05/10/2023	ID Prefix F0686 Reg. # 483.25(b)(1)(i)(ii) LSC	Correction Completed 04/25/2023
ID Prefix F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 04/28/2023	ID Prefix F0759 Reg. # 483.45(f)(1) LSC	Correction Completed 04/14/2023	ID Prefix F0760 Reg. # 483.45(f)(2) LSC	Correction Completed 04/24/2023

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315267	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing		DATE OF REVISIT 6/6/2023	Y3
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0812	Correction	ID Prefix F0842	Correction	ID Prefix F0847	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. # 483.70(n)(2)(i)(ii)(3)-(5)	Completed
LSC	04/12/2023	LSC	05/11/2023	LSC	05/01/2023
ID Prefix F0867	Correction	ID Prefix F0880	Correction	ID Prefix F0919	Correction
Reg. # 483.75(c)(d)(e)(g)(2)(i)(ii)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(g)(1)(2)	Completed
LSC	04/12/2023	LSC	05/10/2023	LSC	04/12/2023

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 4/11/2023		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 060418	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 6/6/2023	Y3
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	05/03/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <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 4/11/2023		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

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

PRINTED: 12/30/2024
FORM APPROVED
OMB NO. 0938-0391

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E 000	Initial Comments	E 000			
K 000	<p>An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 04/11/23. The facility was found to be in compliance with 42 CFR 483.73.</p> <p>INITIAL COMMENTS</p> <p>A Life Safety Code Survey was conducted by the Health Care Management Solutions LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 04/11/23 and was found not to be in compliance with requirements for participation in Medicare/Medicaid at 42 CFR 483.90 (A) Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), chapter 19 EXISTING health care occupancy.</p> <p>Abigail House for Nursing and Rehabilitation was constructed in 1987 with the C-wing constructed in 1990. There is no fire door separation between the two buildings. The 1987 section of the facility is one story with concrete flooring and concrete steel deck roofing and block bearing walls with metal studs and a concrete and brick exterior. The C-wing or 1990 section of the facility has wood frame roofing trusses and plywood sheathing. Abigail House for Nursing and Rehabilitation is therefore a type V (III) combustible construction with a complete sprinkler system and smoke detection in all bedrooms and corridors. The facility has a 400 KW (kilowatt) diesel generator. The facility does not have load test information available. The facility has 169 occupied beds. The facility has nine smoke zones.</p>	K 000			

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

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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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K 211 SS=E	<p>Means of Egress - General CFR(s): NFPA 101</p> <p>Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of all obstruction or impediments to full instant use in the case of fire or other emergency for one of 13 exits in accordance with NFPA 101 Life Safety Code (2012 edition) Section 7.1.10.1. This deficient practice had the potential to affect five residents observed in the area who would utilize the exit.</p> <p>Findings include: An observation of an exit door labeled "4" on 04/11/23 at 11:05 AM revealed the corridor door led to a small corridor of 20 feet that led to an exit discharge. The small corridor was found to contain over 20 sheets of fire rated plastic boards measuring eight feet in length by four feet in width. Also, cut up pieces of fire rated board were all over the floor too numerous to count. The corridor also contained a three foot long by two-foot-wide cart on wheels containing five boxes of ceiling tile parked directly in front of the exit door. The corridor door was labeled as an exit with an illuminated sign stating "Exit." The floor plan on the wall also labeled the area as an exit.</p>	K 211	<p>K211</p> <ol style="list-style-type: none"> 1. The corridor by Exit 4 was cleared and cleaned from all the fire rated materials. The cart was immediately moved from the exit door. 2. All exit doors and corridors will be clear and free of obstruction 3. All exit doors will be checked weekly by Maintenance to ensure they are free of obstructions 4. Maintenance Director will report findings to the QA committee on a quarterly basis for all 4 quarters. 	4/12/23	

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K 211	Continued From page 2 An interview with the U.S. FOIA (b)(6) at the time of the observation indicated he was in the process of correcting the problem when the surveyor entered the building, however the U.S. FOIA (b)(6) verified that objects remained in the small corridor and were blocking the egress.	K 211			
K 341 SS=E	NJAC 8:39-31.1(c), 31.2(e) Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure that five of 244 photo electric smoke detectors were greater than 36 inches from ceiling air diffusers in accordance with NFPA 72 National Fire Alarm	K 341	K341 1. The 5 smoke detectors were moved to greater than 36 inches from any air diffusers in accordance with NFPA 72.	4/26/23	

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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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K 341	<p>Continued From page 3 and Signaling Code (2010 Edition) Section 29.8.3.4.(6). This deficient practice had the potential to affect 88 residents in three smoke zones.</p> <p>Findings include:</p> <p>An observation of a smoke detector in the corridor near bedroom 215 on 04/11/23 at 9:30 AM revealed the smoke detector was 18 inches from a heating and cooling air diffuser as measured by the U.S. FOIA (b)(6).</p> <p>An observation of a smoke detector, located in the corridor near bedroom 201 on 04/11/23 at 09:55 AM revealed the smoke detector was 18 inches from a heating and cooling air diffuser as measured by the U.S. FOIA (b)(6).</p> <p>An observation of a smoke detector, located in the corridor near bedroom 317 on 04/11/23 at 11:10 AM revealed the smoke detector was 26 inches from a heating and cooling air diffuser as measured by the U.S. FOIA (b)(6).</p> <p>An observation of a smoke detector, located in the corridor near bedroom 406 on 04/11/23 at 11:15 AM revealed the smoke detector was 4 inches from a heating and cooling air diffuser as measured by the U.S. FOIA (b)(6).</p> <p>An observation of a smoke detector, located in the corridor near bedroom 404 on 04/11/23 at 11:15 AM revealed the smoke detector was 16 inches from a heating and cooling air diffuser as measured by the US FOIA (b)(6).</p> <p>A review of the most recent fire alarm inspection on 02/03/23 revealed the facility has 244 smoke</p>	K 341	<p>2. All residents have the potential to be affected by this practice</p> <p>3. US FOIA (b)(6) was educated on the need to keep all smoke detectors greater than 36 inches from any ceiling air diffusers in accordance with NFPA 72. Maintenance Director will check all smoke detectors on a quarterly basis.</p> <p>4. Maintenance Director will report his findings to the QA Committee on a quarterly basis for all 4 quarters</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315267	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/11/2023
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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K 341	Continued From page 4 detectors as part of the alarm system. The report did not address smoke detectors that have been installed too close to air diffusers in the ceilings. An interview with the U.S. FOIA (b)(6) at the time of each observation verified the measurements of the smoke detectors to the heating and cooling air diffusers. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 341			
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to complete a smoke detection sensitivity test for all 244 photo electric smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all 169 residents. Findings include: A review of fire safety records, located in an untitled red binder provided by the U.S. FOIA (b)(6) at the fire alarm tab revealed the most	K 345	K345 1. NJ Ex Order 26.4b1 will complete the smoke sensitivity testing on May 11, 2023 in accordance with NFPA 72. 2. All residents have the potential to be affected by this practice 3. The US FOIA (b)(6) was re-inserviced on the smoke detection sensitivity testing that has to be completed once every two years in accordance with	5/11/23	

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K 345	Continued From page 5 recent fire alarm inspection on 08/05/22 and prior reports of 08/12/21 and 02/09/21 did not include a smoke detection sensitivity test. An observation on 04/11/23 from 9:25 AM to 11:52 AM revealed the facility had smoke detection in all corridors every 30 feet and all bedrooms. The facility did not have a self-testing fire alarm system. An interview with the U.S. FOIA (b)(6) on 04/11/23 at 3:00 PM revealed the facility did not have a smoke detector sensitivity test from the past two years and the facility alarm system was not a self-testing system.	K 345	the NFPA 72. 4. Maintenance Director added the smoke sensitivity testing inspection to his log sheet to ensure it is compliant with NFPA 72. The inspection log sheet will be brought quarterly to QA meetings.		
K 372 SS=E	NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72 Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility	K 372		4/24/23	
			K372		

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K 372	<p>Continued From page 6</p> <p>failed to ensure that four of nine smoke barriers were protected by a system or material capable of restricting the transfer of smoke and that smoke barriers were continuous from the floor to the ceiling in accordance with NFPA 101 Life Safety Code (2012 edition) Section 8.5.2. This deficient practice had the potential to affect 138 residents.</p> <p>Findings include:</p> <p>An observation on 04/11/23 at 2:40 PM of a smoke barrier wall located near bedroom 117, revealed above the ceiling tile and cross-corridor doors, a one quarter size hole (two-inch diameter) with blue wires running through the dry wall, another quarter size hole with black wires running through the dry wall, and a nickel size hole (one inch diameter) with black wires running into the dry wall to the other side, all of which were not sealed.</p> <p>An observation on 04/11/23 at 2:45 PM of the smoke barrier wall located near bedroom 102, revealed above the ceiling tile and the cross-corridor doors, a quarter size (two-inch diameter) hole with blue wires running into the dry wall that was not sealed.</p> <p>An observation on 04/11/23 at 2:50 PM of the smoke barrier wall located near bedroom 225, revealed above the ceiling tile at cross-corridor doors, a hole measuring the size of a golf ball or three inches in diameter with black wires penetrating the dry wall and not sealed.</p> <p>An observation on 04/11/23 at 2:55 PM of the smoke barrier wall located near bedroom 203, revealed above the ceiling tile at cross corridor</p>	K 372	<ol style="list-style-type: none"> The 4 smoke barriers were repaired to ensure they are restricting the transfer of smoke and the smoke barriers are continuous from floor to ceiling. All residents have the potential to be affected by this practice US FOIA (b)(6) re-inserviced on the need for the smoke barriers to be completely sealed to ensure they are capable of restricting transfer of smoke, Maintenance Director/designee will inspect the smoke barriers on a monthly basis. Maintenance Director will report his findings to the QA committee on a quarterly basis for all 4 quarters. 		

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K 372	Continued From page 7 doors, a quarter size hole (two inches in diameter) with blue wires running into the dry wall that was not sealed. An interview with the U.S. FOIA (b)(6) at the time each observation indicated that a computer technician ran wires through the smoke walls a couple of months ago and did not back track to make repairs in the wall.	K 372			
K 741 SS=E	NJAC 8:39-31.1(c), 31.2(e) Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is	K 741		5/7/23	

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K 741	<p>Continued From page 8 permitted. 18.7.4, 19.7.4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interview, and policy review, the facility failed to ensure safe ash trays and a metal self-closing container were provided in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.7.4. This deficient practice had the potential to affect 45 smokers.</p> <p>Findings include:</p> <p>An observation of the smoking area, in the courtyard, on 04/11/23 at 11:35 AM, revealed 13 residents smoking without ash trays. Residents were flicking their ashes on the ground. One ash tray was present on top of a garbage can at the end of the canopy away from residents but not used by any residents. Five cigarette towers were present and used by the facility for ash trays although many residents could not reach the opening of the towers or flick ashes into the small tower opening.</p> <p>Further observation of the smoking area revealed no self-closing metal container available to dump the cigarette butts into from the ash trays after smoking. The US FOIA (b)(6) located the cigarette butt self-closing can in the mud. The pedal to open the can was broken. The can had to be opened by hand and unlocked. The can was opened and found to have wet used cigarette butts and mud inside. The can was not used at the previous smoking session on 04/11/23 at 8:30 AM as verified by the U.S. FOIA (b)(6) on 04/11/23 at 11:45 AM.</p>	K 741	<p>K741</p> <ol style="list-style-type: none"> 1.New ashtrays and a new metal self closing container were purchased for the smoking courtyard. The smoking policy was revised. 2. All residents have the potential to be affected by this practice. 3. The smoking policy was revised and references extinguishing cigarettes in ashtrays only and the disposing of cigarette butts at the end of the day. Abigail House has a non-smoking indoors policy. Activities/Security were all re-inserviced on the revised smoking policy 4. Assitant Administrator will monitor weekly by randomly checking the smoke sessions for compliance with the revised policy and will report to the QA committee on a quarterly basis 		

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K 741	Continued From page 9 Interview with Resident 1 (R1) on 04/11/23 at 11:40 AM revealed R1 sitting in a chair flicking ashes into a green ceramic container measuring four inches wide by four inches long. She stated that was all she had to put her ashes into. An interview with the U.S. FOIA (b)(6) on 04/11/23 at 11:50 AM, who was supervising the smoking session, stated "we have always used the smoking tower." He went onto to state he was not aware the towers did not count as ash trays. The U.S. FOIA (b)(6) also stated he was not aware of the location of a self-closing waste can for cigarette butts. Interview with the U.S. FOIA (b)(6) at the time of the observation verified the condition of the area and residents smoking without ash trays and without the use of a self-closing metal can. Review of the facility policy no date titled "Smoking Policy" revealed the policy lacked references to safety while smoking such as safe use of ash trays at all times, extinguishing cigarettes in ash trays only, disposing of all ashes and cigarette butts when finished smoking, and how and when and where to dispose of such cigarette butts. The policy also lacked a reference to final disposal of all cigarette butts at the end of the day or smoking session. The policy also indicated "Abigail House is a non-smoking facility."	K 741			
K 918 SS=F	NJAC 8:39-31.2(e), 31.6(e) Electrical Systems - Essential Electric System CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K 918		4/24/23	

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K 918	<p>Continued From page 10</p> <p>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and interview, the facility failed to ensure that the 400 KW (kilowatt) stand-by diesel generator had a load bank test in accordance with NFPA 110 Standard for Emergency and Stand by Power</p>	K 918	<p>K918</p> <p>1. A generator load test was completed by NJ Ex Order 26.4b1 on 4/24/23 in accordance with NFPA 110</p>		

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K 918	<p>Continued From page 11 Systems (2010 Edition) Sections 8.3.4. and 8.4.5.9.1. This deficient practice had the potential to affect all 169 residents.</p> <p>Findings include:</p> <p>An observation of the stand-by diesel generator on 04/11/23 at 10:10 AM revealed the generator was positioned outdoors. The generator was labeled as 400 KW.</p> <p>A review of the fire safety records from the untitled red binder provided by the U.S. FOIA (b)(6) revealed a load bank test was not available. The facility did not have information related to routine load testing at 30% or greater including no amperage information or total amperage under load.</p> <p>An interview with the U.S. FOIA (b)(6) on 04/11/23 at 3:00 PM verified he did not have a load bank test.</p> <p>NJAC 8:39-31.2(e) NFPA 99, 110</p>	K 918	<p>2. All residents have the potential to be affected by this practice</p> <p>3. U.S. FOIA (b)(6) was re-inserviced on the requirement to have a load bank test completed every 3 years in accordance with NFPA 110.</p> <p>4. Maintenance Director added the load bank test to his inspection log sheet to ensure it's completed in accordance with NFPA 110. The inspection log sheet will be reviewed monthly and will be brought to the QA meetings on a quarterly basis.</p>		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315267	Y1	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	DATE OF REVISIT 6/6/2023	Y3
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 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 _____ Reg. # NFPA 101 LSC K0211	Correction Completed 04/12/2023	ID Prefix _____ Reg. # NFPA 101 LSC K0341	Correction Completed 04/26/2023	ID Prefix _____ Reg. # NFPA 101 LSC K0345	Correction Completed 05/11/2023
ID Prefix _____ Reg. # NFPA 101 LSC K0372	Correction Completed 04/24/2023	ID Prefix _____ Reg. # NFPA 101 LSC K0741	Correction Completed 05/07/2023	ID Prefix _____ Reg. # NFPA 101 LSC K0918	Correction Completed 04/24/2023
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

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 4/11/2023		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		