

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/27/2023
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 Complaint #: NJ#165979, NJ#163991, NJ#169630 Census: 176 Sample Size: 5 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Complaint #: 165979 Based on observation, interviews, review of the medical record, and other pertinent facility documentation on 12/29/23, it was determined that the facility failed to consistently document Activities of Daily Living (ADL) care as being provided to Resident #3 on the "ADL Documentation" form. This deficient practice was identified for 1 of 5 residents (Resident #3) reviewed for ADL care and evidenced by the following: Review of the Admission Record revealed that Resident #3 was admitted to the facility on No Exec Order with medical diagnoses which included but were	F 677	1. Resident # 3 has been discharged from the facility. The facility has completed a risk management and incident/accident form for Resident #3. 2. The facility has determined that all residents have the potential to be effected. 3. The Director of Nursing/designee has in-serviced all Nurses and Certified Nurses Assistants in providing timely assistance with Activities of Daily Living, providing care according to the plan of care and documentation. Plan of Care will be documented after Activities of Daily	1/19/24	

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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F 677	<p>Continued From page 1</p> <p>not limited to: NJ Exec Order 26.4b1</p> <p>[REDACTED]</p> <p>Review of Resident #3's comprehensive Minimum Data Set (MDS) an assessment tool, dated NJ Exec Order 26.4b1, indicated that Resident #3 had a Brief Interview for Mental Status (BIMS) score of U.S. FOIA (b)(6) which indicated NJ Exec Order 26.4b1. The MDS also indicated Resident #3 needed NJ Exec Order 26.4b1 with ADL tasks including NJ Exec Order 26.4b1.</p> <p>Review of the Resident #3's Care Plan (CP) dated NJ Exec Order 26.4b1, under the "Focus" section, revealed Resident #3 required NJ Exec Order 26.4b1 with ADLs due to NJ Exec Order 26.4b1. Under the "Goals" section, revealed "to be dressed appropriately, well groomed, and comfortable daily." Under the "Interventions/Tasks" section, revealed NJ Exec Order 26.4b1. Check and change every 2 hours and as needed."</p> <p>Review of Resident #3's "ADL Documentation" form for NJ Exec Order 26.4b1 revealed blank spaces indicating the tasks were not documented as being completed as follows:</p> <p>Eating on the day shift on NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) on the evening shift on NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) on the evening shift on NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) on the overnight shift on NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1).</p>	F 677	<p>Living are completed.</p> <p>The Director of Nursing will maintain compliance. QA program includes audit tool for monitoring compliance. The Director of Nursing will conduct random audits of personal hygiene and documentation three times a week for three months to monitor compliance. Random observations of resident ADL documentation will also take place three times a week for three months.</p> <p>4. Any negative findings will be communicated to the Administrator for corrective actions. Aggregate findings and audits will provided to the QA committee for review quarterly for 3 months, and analyzed for recommendations for changes in policy/procedure/and or practice.</p>		

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F 677	Continued From page 2 During an interview with the surveyor on 12/29/23 at 9:12 AM, the U.S. FOIA (b)(6) stated the Certified Nursing Assistants (CNAs) were responsible for recording ADL care, when completed, by the end of their shift. The U.S. FOIA (b)(6) stated if there were blank spaces on the ADL form, it indicates it's not recorded in the kiosk. The U.S. FOIA (b)(6) further stated, "It is important to record ADL care, so we know ADL care was being done. If it's not recorded, it's not done." During an interview with the surveyor on 12/29/23 at 9:43 AM, the U.S. FOIA (b)(6) stated that the CNAs were responsible for documenting ADL care immediately after care was provided. The U.S. FOIA (b)(6) stated if ADL care was not documented, there was really no proof that it was done. The U.S. FOIA (b)(6) stated it was important to document ADL care to keep a record and follow-up of any changes in the future. The U.S. FOIA (b)(6) further stated, "If ADL care was not provided, the CNAs should have recorded a not applicable (n/a) in the blank spaces. All blank spaces should be filled in." During an interview with the surveyor on 12/29/23 at 9:50 AM, the U.S. FOIA (b)(6) stated the CNAs were responsible for ADL care and it should be documented in the kiosk. The U.S. FOIA (b)(6) stated that if it was not documented on the ADL documentation sheet in the kiosk, it meant ADL care wasn't rendered. The U.S. FOIA (b)(6) in the presence of the surveyor, reviewed the ADL documentation sheets for Resident #3. The U.S. FOIA (b)(6) stated, "I wouldn't know if ADL care was completed if there were blank spaces on the ADL documentation sheet." The U.S. FOIA (b)(6) further stated, "It is important to document on the ADL	F 677			

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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F 677	Continued From page 3 documentation sheet because it is used as a communication tool for the nurses." The facility policy, "ADL Documentation" dated 9/2023 indicated under the "Procedure" section, "1. CNA staff responsibility is to chart ADLs in Point Click Care (PCC) for residents who they are assigned, 2. CNA staff are prompted by PCC in each category of ADLs, 3. Staff should indicate level of assistance and/or if the ADL did not occur on their shift, 4. Documentation is to be completed each shift, and 5. Unit Managers (UMs), supervisors and nurses are responsible for completing audit checklist for point of care (POC) monitoring each shift to ensure that all documentation is done." NJAC 8:39-27.1 (a) 8:39-35.2(g).	F 677			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060418	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/27/2023
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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	<p>Initial Comments</p> <p>Complaint#: NJ#165979, NJ#163991, NJ#169630</p> <p>CENSUS: 176</p> <p>SAMPLE SIZE: 5</p> <p>The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.</p>	S 000		
S 560	<p>8:39-5.1(a) Mandatory Access to Care</p> <p>(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint # NJ#165979, NJ#163991</p> <p>Based on interview and review of pertinent facility documentation on 12/27/23, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 6 out of 14 day shifts reviewed.</p> <p>Findings include:</p>	S 560	<p>1. All residents have the potential to be affected by a staff shortage. However no care issues were identified on the six shifts that were found deficient. The Staffing Coordinator was in-serviced regarding the tag S560 to ensure that the staffing requirements are met.</p> <p>2. All residents are at risk to be affected by the deficient practice.</p>	1/19/24

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S 560	<p>Continued From page 1</p> <p>Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:</p> <p>One Certified Nurse Aide (CNA) to every eight residents for the day shift.</p> <p>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 CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and</p> <p>One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.</p> <p>The surveyor requested staffing for the weeks of 12/10/23 to 12/16/23, and 12/17/23 to 12/23/23.</p> <p>As per the "Nurse Staffing Report," completed by the facility for the weeks of 12/10/23 to 12/23/23, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows:</p> <ul style="list-style-type: none"> -12/10/23 had 19 CNAs for 173 residents on the day shift, required at least 22 CNAs. -12/16/23 had 19 CNAs for 172 residents on the day shift, required at least 21 CNAs. -12/17/23 had 16 CNAs for 174 residents on 	S 560	<p>3. Sign on and referral bonuses are in place along with overtime and weekend bonuses to ensure the facility is staffed appropriately. The facility also uses external resources to increase recruitment of direct staff and to ensure the availability of other staffing resources (e.g. contracted staff) in the event of a staffing shortage.</p> <p>For the next month, the Administrator/designee will review the projected staffing hours daily to ensure staffing hours are above state minimum.</p> <p>4. Findings will be submitted for 3 months to the monthly QAPI committee who will determine further inventions as needed.</p>	

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S 560	Continued From page 2 the day shift, required at least 22 CNAs. -12/18/23 had 19 CNAs for 173 residents on the day shift, required at least 22 CNAs. -12/22/23 had 19 CNAs for 172 residents on the day shift, required at least 21 CNAs. -12/23/23 had 19 CNAs for 176 residents on the day shift, required at least 22 CNAs.	S 560		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315267	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 1/22/2024	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 F0677	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.24(a)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/19/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 12/27/2023		<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	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/22/2024
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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	01/19/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 12/27/2023		<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		