STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315267	A. BUILDING _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABIGAIL HOUSE FOR NURSING & REHABILITATION	**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 #'s: 184823 Survey Dates: 4/4/25 to 4/17/25 Census: 179 Sample size: 35 + 2 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 569 SS=D	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law.	F 569		5/2/25

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

Electronically Signed | 05/09/2025

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F 569	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, it was determined that the facility failed to ensure that all residents that maintained a Personal Needs Account (PNA) that approached the limit that could jeopardize a resident's eligibility for [NJ Ex Order 26.4(b)(1] or NJ Ex Order 26.4(b)(1)) received a written notification. This deficient practice was identified for all residents who maintained Personal Needs Accounts at the facility and was evidenced by: A review of the Patient Fund Balances Report through [NJ Exec Order 26.4b] revealed a list of [NJ Exec O] active resident names with a balance of NJ Exec Order 26.4b1 There were nine ([NJ]) residents listed with PNA funds that range from NJ Exec Order 26.4b1 . There were ten ([NJ Exe]) residents listed with PNA funds that range from NJ Exec Order 26.4b1 On 4/7/25 at 12:02 PM, the surveyor interviewed the U.S. FOIA (b)(6)) in the presence of the survey team who stated her role regarding the PNA was that she reviewed the monthly balances and completed the transfers and maintained the trust account. The [U.S. FOIA (b] stated that she tried to maintain each resident's PNA balance under [NJ Ex Order 26.4(b)(1)]. She stated that if she noticed the account was close to [NJ Ex Order 26.4(b)(1)] she would reach out to the resident to see what they needed or wanted. The [U.S. FOIA (b] stated that she went to the units twice a week and resident were also able to come to her office. At that time, the [U.S. FOIA (b] stated Resident #40 had just received the [NJ Exec Order 26] for the month and was over by [NJ Exec Order 26]; for Residents #42, #45, #46, and #63 she would find out what they needed; for	F 569	1.Business office Manager purchased: personal clothing for Resident #40. Personal clothing & personal care items were purchased for Resident #42. Personal clothing & personal care items were purchased for Resident # 45. Personal clothing was purchased for Resident #46. Personal clothing and shoes were purchased for Resident #63. A pre-paid, irrevocable burial was purchased for Resident #79 in the amount of $2,500. Resident #165 Social Security benefits that were deposited incorrectly in the amount of $2,254.10 were refunded back to Social Security via check. An irrevocable, pre-paid burial was purchased for Resident #109 in the amount $2,000.00. Personal Clothing was purchased for Resident #12. The listed purchased above ensured each resident was no longer over-resourced and balances for each resident is under $2,000.00. 2. All residents have the potential to be affected by this deficient practice. 3. [U.S. FOIA (b] was in-serviced by the Administrator on resident PNA accounts. Once a resident reaches $1,800.00 in their PNA, a letter will be sent to resident and/or responsible party by the business office manager to inform them that they are approaching maximum resource. 4. Any resident that is close to being over-resourced will be reported by the	

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F 569	Continued From page 2 Resident #79 they were recently transferred to the facility with NJ Ex Order 26.4(b)(1) but would speak with the resident; for Resident #165 their NJ Ex Order 2 [redacted] were NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1); for Resident #109 there were on U.S. FOIA (b)(6) and would speak with the family; and for Resident #12 the resident NJ Ex Order 26 [redacted] as they NJ Ex Order 26.4(b)(1) once a year. On 4/8/25 at 11:06 AM, the surveyor conducted a follow-up interview with the U.S. FOIA (b) and when asked to provide copies of the notices for residents whose balances were within or approaching NJ Exec Ord of the maximum allowed, the U.S. FOIA (b) stated she did not provide written notices, nor does she document in the resident's medical record that the resident/representative was notified. She stated, "I don't have that capability in my system." On 4/10/25 at 12:22 PM, the surveyor presented the concerns regarding the PNA balances to the facility administration. On 4/11/24 at 9:43 AM, the facility administration had no further information to provide regarding the PNA balances. On 4/11/25 at 10:25 AM, the U.S. FOIA (b)(6 stated that she rectified each one that was over the NJ Exec Order 26.4b1 The U.S. FOIA (b) stated that she provided quarterly statements and when requested but reiterated she did not provide a written statement to residents whose balances were within or approaching NJ Exec Ord of the maximum allowed. She stated she was aware the balance was supposed to be under NJ Exec Order 26.4b1 but was not aware of the written notification to the residents.	F 569	Business Office Manager to the QA committee quarterly.	

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F 569	Continued From page 3 A review of the facility's Job Description - Business Office Employee included, "2. PNA funds a. To post the PNA balances timely." A review of the facility's undated "Personal Needs Accountants Disbursements" policy did not include the process for residents whose balances were within or approaching $200 of the maximum allowed.	F 569		
F 576 SS=D	NJAC 8:39-9.5(c) Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent	F 576		5/5/25

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F 576	Continued From page 4 with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interviews and a review of facility provided documents, it was determined that the facility failed to provide Saturday mail services to residents. This deficient practice was identified for one (1) of one (1) resident interviewed during the Resident Council group meeting (Residents #50) and was evidenced by the following: On 4/7/25 at 10:44 AM, the surveyor conducted the U.S. FOIA (b)(6) meeting with Residents #50, #74, #115, #137, and #152. During U.S. FO, the surveyor asked the residents if they received mail on Saturdays and Resident #50 stated that he/she never received mail on a Saturday while living at the facility. Residents #115 and #137 stated they did not normally receive mail on a regular basis because nobody sent them mail. Residents #74 and #152 did not reply when asked if they received mail on Saturdays. On 4/10/2025 at 12:20 PM, the U.S. FOIA (b)(6) , in the presence of	F 576	1. Business Office Manager went to Post Office, spoke with Supervisor to request mail be delivered on Saturdays for Resident #50 and all other residents. U.S. FOIA (b)(6) , Activities department, and department heads U.S. FOIA (b) (6) on duty were in-serviced by the Administrator on this deficient practice. 2. Resident #50 and all residents have the potential to be affected by this deficient practice. 3. Business Office Manager will sort mail. Activities disperses mail to residents. Administrator on Duty will sort the mail on Saturdays and any personal mail for residents will then be given to Activities to be dispersed to the residents. BOM will audit monthly times 6 months to ensure mail is being delivered on Saturdays.	

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F 576	Continued From page 5 the [U.S. FOIA (b)] and the survey team, stated that he was not sure if the facility received mail on Saturdays. He further stated that the mail was delivered to the business office, which was closed on Saturdays. The [U.S. FOIA (b)(6)] stated that he stopped the mail from coming on Saturdays because the mail was getting lost. On 4/11/2025 at 9:55 AM, the [U.S. FOIA (b)(6)], in the presence of the survey team stated that there were times that the facility did not get mail. He further stated that he was not sure if it was placed on hold because they were considered a business. The [U.S. FOIA (b)(6)] acknowledged the issue should have been looked into but none of the residents complained. On 4/11/25 at 10:28 AM, the surveyor interviewed the U.S. FOIA (b)(6)), who stated that mail was received in the business office, sorted, given to the Activities staff to be distributed to the residents. She stated that the facility had never received mail on Saturdays in the 20 years she has been employed there. She further stated that after surveyor inquiry, she called the post office to see if they could deliver mail to the facility on Saturdays. A review of the facility's undated "Resident Mail" policy, included, "Residents... have the right to send and receive mail privately."	F 576	4. Business Office Manager will report to the QA committee quarterly for the next 2 quarters to ensure mail is being delivered on Saturdays.	
F 584 SS=D	.N.J.A.C. 8:39-4.1 (a)(19) Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean,	F 584		5/7/25

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F 584	Continued From page 6 comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 584		

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F 584	Continued From page 7 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain the resident's room in a sanitary and homelike manner. This deficient practice was evidenced on 1 of 3 resident units ([redacted]) and was evidenced by the following: On 4/4/25 at 10:10 AM, during the initial tour, the surveyor entered an unsampled resident's room (Room [redacted]). The bed remote was noted to have a buildup of a hard brown substance. The bed frame contained a buildup of dust and small particles. The windowsill was also noted to have a buildup of dust. On 4/8/25 at 10:41 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that she cleaned the bed frames and windowsills every day. On 4/8/25 at 12:34 PM, the surveyor interviewed the U.S. FOIA (b)(6)), who stated that she was fully staffed. She further stated that the high-touch areas in the resident rooms were cleaned daily, and any areas that were visibly dirty should be cleaned. She also stated that the bed frames were cleaned each month when the room was carbolized (sanitizing or disinfecting equipment or surfaces to kill germs and prevent the spread of infection). The [redacted] stated that room [redacted] was last cabolized on [redacted] and the next carbolization was scheduled for [redacted]. At that time, the [redacted] confirmed that each room was not scheduled to be carbolized monthly. At that time, the surveyor showed the [redacted] a	F 584	1. Housekeeping cleaned Room [redacted] during afternoon rounds with focused attention on the bed remote to remove brown substance, removing dust from the windowsill, as well as ensuring the bed frame was clear of dust. 2. All residents have the potential to be affected by this deficient practice. 3. The carbolization schedule has been changed to carbolize 2 rooms per day over a five day period. Housekeepers and CNAs have been in-serviced of the new carbolization schedule and the importance of ensuring it is completed. Housekeeping will provide DON/ADON with a monthly calendar of which rooms are scheduled to be carbolized. 4. Environmental Service Director will report to the QA committee quarterly that all rooms have been carbolized within the 30 day period quarterly for the next 4 quarters	

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F 584	Continued From page 8 photo of the dirty areas in the resident's room, she confirmed that it was dirty and should have been cleaned. On 4/8/25 at 12:47 PM, during a follow-up visit to Room [NJ Exec Order], the surveyor observed the bed remote, the bed frame, and the windowsill were still not cleaned. On 04/10/25 at 12:23 PM, the [U.S. FOIA (b)(6)], in the presence of the survey team, stated each resident's room was carbolized once a month. He further stated high touch areas should be cleaned daily and as needed. A review of the facility's undated "Resident Room Cleaning" policy included, "Steps in the Daily Cleaning of a Resident...2. Clean and dust all horizontal surfaces, including furniture, over-bed tables, floormats.." A review of the facility's undated "Complete Room Cleaning" policy included, "1. Complete room cleaning is performed monthly. Each housekeeper will be responsible for one per day. ...3. Complete room cleaning includes moving of all furniture away from walls and cleaning underneath and behind. 4. Complete room cleaning includes disinfection of furniture and any beds or floormats located within the room."	F 584		
F 622 SS=D	NJAC 8:39 - 31.4 (a) Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge-	F 622		4/30/25

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F 622	Continued From page 9 §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger	F 622		

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F 622	Continued From page 10 that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals;	F 622		

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F 622	Continued From page 11 (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on the interview, record review, and review of pertinent documents, it was determined that the facility failed to ensure residents who were discharged to the community had a discharge summary that was completed by the physician. This deficient practice was identified for 1 of 1 resident, (Resident #179), reviewed for discharge. This deficient practice was evidenced by the following: On 4/7/25 at 10:16 AM, the surveyor reviewed the medical record for Resident #179. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included, but not limited to, NJ Exec Order 26.4b1 [redacted]. A review of the most recent Discharge Return Not Anticipated (DRNA) Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed in Section A Identification Information that the discharge (d/c) status was coded [redacted] Further review of the medical records revealed that there was no documented evidence that the physician completed a d/c summary.	F 622	1. Discharge summary was not completed for Resident #179. All nursing staff were in-serviced by [redacted] on this deficient practice. 2. All residents being discharged have the potential to be affected by this practice. 3. [redacted] is completing a discharge summary audit, every time a patient is discharged from the facility. Any discharges not completed by the physician will be addressed directly with attending physician to ensure completion. ADON will update DON immediately of any deficient practice. 4. ADON will monitor and report findings weekly to DON for 30 days and report to the QA committee on a quarterly basis for 4 quarters.	

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	315267	A. BUILDING _____ B. WING _____	C 04/17/2025

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F 622	Continued From page 12	F 622		

On 4/7/25 at 12:39 PM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated that the physicians completed a discharge summary and documented in the electronic medical record (EMR) within 72 hours of the resident being discharged.

On 4/8/25 at 8:35 AM, the surveyor conducted a follow up interview with the U.S. FOIA (b) who stated that the physicians did not complete a discharge summary but completed weekly visit notes. She further stated the only time the physician would complete a discharge summary was if the discharge day fell on the same day as the weekly visit.

On 4/10/25 at 10:13 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM #1) who stated for the discharge summary the nurses ensure they received the orders from the physician. She stated that all departments completed a section on the discharge summary, and anything related to care the nurses filled out. RN/UM #1 stated that the physician wrote a discharge summary in the Progress Notes (PN) and that every resident should have a discharge summary.

On 4/10/25 at 10:16 AM, the surveyor interviewed the U.S. FOIA (b) (6) for Resident #179 in the presence of the U.S. FOIA (b)(6)) who stated that residents who were scheduled to be discharged would have a discharge summary which included what was done during the resident's stay at the facility and medications that were ordered for post-discharge. He stated that the notes were done in a separate system from the facility and had to be uploaded into the EMR.

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F 622	Continued From page 13	F 622		

The U.S. FOIA (b) (6) stated that there should be a discharge summary for every resident that was discharged to the community to ensure they were discharged in stable condition. The U.S. FOIA (b) (6) stated that the U.S. FOIA (b) could also complete a physician's discharge summary.

On 4/10/25 at 10:20 AM, the U.S. FOIA (b) stated that she was the U.S. FOIA (b) for the U.S. FOIA (b) (6). She stated that she remembered Resident #179's name but did not remember if a discharge summary was completed. At that time, both the U.S. FOIA (b) (6) and the U.S. FOIA (b) reviewed the EMR.

On 4/10/25 at 10:21 AM, upon review of the EMR, the U.S. FOIA (b) (6) stated that it was probably one they missed. At that time, they both stated they were away during the timeframe the resident was discharged. The U.S. FOIA (b) (6) stated they had coverage but did not have anyone to complete the discharge summaries. The U.S. FOIA (b) (6) confirmed there was no physician's discharge summary for the resident. He stated he would have to add a note in there now. He further stated they tried to complete and upload the discharge summary into the EMR within 30 days. They both acknowledged it was longer than 30 days and that it should have been completed prior to surveyor inquiry,

On 4/11/25 at 9:52 AM, the U.S. FOIA (b) in the presence of the U.S. FOIA (b)(6) and the survey team stated that the physician's discharge summary should have been completed. The U.S. FOIA (b) and the U.S. FOIA (b)(6) confirmed it was not done prior to surveyor inquiry. The U.S. FOIA (b) acknowledged it should have been done within 30 days of the resident's discharge.

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F 622	Continued From page 14 A review of the facility's "Interdisciplinary Discharge Summaries" policy dated reviewed September 2024, included, "4. The Unit Manager will notify the Physician. The Physician will supply necessary orders and scripts. The Physician will also write his/her Physician Discharge Summary/Progress Note to be put in the patient's chart." A review of the facility's "Transfer and Discharges" policy dated reviewed September 2024, included, "4. Documentation a. the attending physician will document the reason for the transfer/discharge in the resident's medical records." NJAC 8:39-4.1(a)(31); 36.1(b)(c)	F 622		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (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	F 657		5/23/25

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F 657	Continued From page 15 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to revise a resident's individual comprehensive care plan after NJ Exec Order 26.4b1 medications were discontinued for 1 of 3 residents (Resident #38) reviewed for NJ Exec Order 26.4b1. This deficient practice was evidenced by the following: On 4/4/25 at 10:13 AM, the surveyor observed Resident #38 lying in bed. The resident was not experiencing any NJ Exec Order 26.4b1. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to, U.S. FOIA (b)(6). A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated U.S. FOIA (b)(6), included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 which indicated the resident's cognition was NJ Exec Order 26.4b [redacted] Further review of the MDS revealed	F 657	1. For Resident #38, NJ Exec Order 26.4b1 [redacted] care plans were updated to reflect the medication was discontinued. All nurses were in-serviced by U.S. FOIA (b)(6) on this deficient practice. 2. Unit Managers will update and audit care plans weekly, based on U.S. FOIA (b)(6) weekly visit with residents. Should a physician discontinue a psych med, care plan will be updated immediately by Unit Manager. 3. Random audits of care plans will take place by DON/ADON weekly for 4 weeks, monthly for 2 months, and then quarterly for 2 quarters. 4. DON/ADON will report their findings to the QA committee for 3 quarters.	

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F 657	Continued From page 16 the only [redacted] medication the resident received in the last seven days was an [redacted] A review of the individual comprehensive care plan (ICCP) included a focus area, initiated [redacted], that the resident was on an [redacted]) related to depression. Further review of the ICCP included a focus area, initiated [redacted], that the resident was on an [redacted] medication [redacted] related to [redacted]. A review of the Order Summary Report (OSR), dated as of [redacted], included the following physician orders (PO) for [redacted] medications: A PO, dated [redacted], for [redacted]) give [redacted] for unspecified [redacted]. There were no active orders for [redacted] or [redacted] medications. A review of the discontinued medications listed in the resident's Electronic Medical Record (EMR) revealed the following: The PO for [redacted] was discontinued with an end date of [redacted]. The PO for [redacted] was discontinued with an end date of [redacted]. On 4/9/25 at 11:26 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated the [redacted] were responsible for updating the residents' care plans. When asked about discontinued [redacted] medications, the [redacted] stated the care plan should be revised the same day the medication was discontinued.	F 657		

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F 657	Continued From page 17 The U.S. FOIA (b)(6) explained that it was important for the care plans to accurately reflect the residents for continuity of care and "so the staff know how to take care of the resident as a whole." On 4/9/25 at 1:12 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated the U.S. FOIA (b) were responsible for updating the residents' care plans. When asked about discontinued U.S. FOIA (b)(6) medications, the U.S. FOIA (b)(6) stated the care plan should be revised the same day the medication was discontinued. The U.S. FOIA (b) explained that it was important for the care plans to accurately reflect the residents to make sure the resident received appropriate care. A review of the facility's "Care Plans" policy, dated July 2024, included, "Assessments of the resident are ongoing and care plans are revised as information about the residents and the residents' conditions change." Further review of the policy also included: "The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met; c. When the resident has been readmitted; and d. At least quarterly, in conjunction with the required quarterly MDS assessment." NJAC 8:39-27.1(a)	F 657		
F 658 SS=D	.. Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		4/18/25

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F 658	Continued From page 18 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to administer [NJ Ex Ord] medication according to the physician prescribed [NJ Exec Order 26.4b1] for 1 of 3 residents (Resident #33) reviewed for [NJ Ex Orde] This deficient practice was evidenced by: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health	F 658	1. Immediate phone call to physician to verify [NJ Ex Ord] scale. [NJ Exec Order 26] order has been updated to reflect NJ Ex Order 26.4(b)(1), and [NJ Exec Order 26.4b1] has been updated to reflect NJ Exec Order 26.4b1 as needed. All nurses have been in-serviced on Resident #33 and to call the physician if [NJ Ex Ord] medication administered is not effective and is documented in nurses note. 2. Resident #33 and all residents have the potential to be affected by this deficient practice. 3. Staff will be in-serviced by ADON/Designee every six months on following pain scale and contacting physician if medication is not affective. Spot checks will be done monthly for 6 months 4. ADON/Designee will report to the QA committee for 2 quarters.	

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F 658	Continued From page 19	F 658		

counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."

On 4/8/25 at 10:19 AM, the surveyor observed Resident #33 sitting in the dayroom participating in an activity. The resident was not available for interview, but had no visible signs or symptoms of pain.

A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to, NJ Exec Order 26.4b1

A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b1 included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 which indicated the resident's NJ Exec Order 26.4b1. Further review of the MDS included the resident had NJ Exec O "almost constantly" and rated the intensity of his/her NJ Exec Orde NJ Exec Order 26.4b1."

A review of the individual comprehensive care plan (ICCP) included a focus area, revised NJ Ex Order 26.4b, that the resident had NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1 and had a long history of NJ Exec Order 26.4b1. Interventions included: "Assess for NJ Ex Orde on ongoing basis," and "Administer NJ Exec Order 26.4b1 as ordered."

A review of the Order Summary Report (OSR), dated as of NJ Exec Order 26, included the following physician orders (PO):
A PO, dated NJ Exec Order 26, for NJ Exec Order 26.4b1

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NJ Exec Order 26.4b1 every NJ Exec Ord hours NJ Exec Order 26.4 (NJ Exec Order 26.4b1).
A PO, dated NJ Exec Order 26.4b, for NJ Exec Order 26.4b1 give two tablets by mouth every NJ Exec Or hours as needed for NJ Exec Order 26.4b1; NJ Ex Order 26.4(b)(1)

A review of the NJ Ex Order 26.4(b)(1) Medication Administration Record (MAR) included the PO for NJ Exec Order 26.4 The NJ Exec Order 26.4 was administered for NJ Ex Ord greater than NJ Ex on the following dates:
On NJ Exec Order 26.4b1 NJ Exec Order 26 was given for a NJ Ex Ord rating of NJ.
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On NJ Exec Order 26.4b1 was given for a NJ Ex Ord rating of NJ Ex.

On 4/9/25 at 11:26 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated that if the resident's NJ Ex Order 26.4(b)(1) was greater than the NJ Ex Ord scale for the as needed NJ Ex Ord medication, the nurse should call the physician for clarification and further recommendations. The U.S. FOIA (b) (6) explained that it was important to administer NJ Ex Ord medication according to the

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F 658	Continued From page 21 physician's order so the resident could have relief and ensure the [NJ Ex Ord] medication was effective. On 4/9/25 at 12:28 PM, the surveyor interviewed the [U.S. FOIA (b)(6)] who stated the nurse should clarify the as needed [NJ Ex Ord] medication order prior to administering the medication if the resident's [NJ Ex Ord] level did not match the physician's order. On 4/9/25 at 1:12 PM, the surveyor interviewed the [U.S. FOIA (b)(6)]) who stated if a resident's [NJ Ex Ord] level did not match the PO for as needed [NJ Ex Ord] medication, the nurse should notify the physician. The [U.S. FOIA (b)] explained it was important to administer [U.S. FOIA (b)(6)] according to the physician's order "so the resident is being taken care of." A review of the facility's "Pain Management" policy, dated September 2024, included the following: "2. The best modality for pain relief will be established and ordered by the physician. 3. Modality and/or medication will be changed in accordance with need to control discomfort. 4. Modality and/or medication will be utilized, as needed, to enhance maximum level of functioning. 5. Pain management will be addressed as an approach to a problem/need or plan of care."	F 658		
F 689 SS=D	NJAC 8:39-27.1(a) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		4/18/25

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F 689	Continued From page 22 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 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documents, it was determined that the facility failed to ensure a NJ Exec Order 26.4b1 were in place for a resident with a history of [redacted]. This deficient practice was identified for 1 of 2 residents reviewed for [redacted] (Resident #382) On 4/4/25 at 10:43 AM, the surveyor observed Resident #382 awake and alert lying in bed. The surveyor observed NJ Exec Order 26.4b1 folded and stored at the head of the bed leaning against the wall. The resident stated he/she has had [redacted] and stated, 'NJ Exec Order 26.4b1 On 4/7/25 at 9:00 AM, the surveyor observed Resident #382 lying in bed with his/her eyes closed. The resident had a [redacted] in place to the resident's [redacted], but the [redacted] for the resident's [redacted] was folded up and not in place. On 4/9/25 at 8:18 AM, the surveyor observed Resident #382 in bed with their eyes closed. The resident had a [redacted] in place to the resident's [redacted], but the [redacted] for the resident's [redacted] was folded up and not in place. The surveyor reviewed the medical record for Resident #382.	F 689	1. Order was added for [redacted] in the TAR for Resident # 382. Any resident who has had a [redacted], a [redacted] was added as an intervention, if there was no [redacted] in place. All nurses were in-serviced by DON/ADON on this deficient practice. 2. Resident #382 and all residents have the potential to be affected by this deficient practice. 3. When a fall occurs and is reviewed with the ICD team, if floor mats are needed an order will be written for floor mats immediately. Falls audit is done weekly by DON/ADON for one month, then monthly for two months, and then quarterly for 2 quarters. 4. DON/ADON will report quarterly to the QA committee for 3 quarters.	

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F 689	Continued From page 23	F 689		

A review of the Admission Record face sheet, an admission summary, revealed the resident had diagnoses which included but were not limited to, NJ Exec Order 26.4b1 [redacted].

A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident's NJ Exec Order 26.4b1 [redacted]. Further review of the MDS revealed the resident had a fall in the last month prior to admission to the facility.

A review of the individualized comprehensive care plan (ICCP) included a focus area that the resident was at [redacted] and had a [redacted] on [redacted] Interventions included: Continue the use of safety alarm and NJ Ex Order 26.4(b)(1) of the bed.

A review of the Order Summary Report (OSR) dated as of [redacted], included the following physician's order (PO):

-A PO dated [redacted], for [redacted] Precautions: [redacted]."

A review of the [redacted] Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not include the above physician's order for nursing staff to sign off that the [redacted] were being checked for proper placement.

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F 689	Continued From page 24 On 4/9/25 at 12:30 PM, the surveyor interviewed Certified Nursing Assistant (CNA #4), who stated Resident #382 sometimes needed [NJ Ex Order 26.4(b)(1)] but today needed NJ Ex Order 26.4(b)(1). CNA #4 further stated that the resident was on [NJ Exec] precautions and that both [NJ Ex Order 26.4(b)(1)] should be in place when the resident was in bed. On 4/9/25 at 12:34 PM, the surveyor interviewed Licensed Practical Nurse (LPN #3), who stated that every time the resident was in bed, that both [redacted] should be in place. LPN #2 also stated that there should be a physician's order for [NJ Ex Orde] [redacted] and the nurse would document that the [NJ Ex Orde] were in place in the TAR. On 4/9/25 at 12:39 PM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM #1) who stated that residents with [NJ Ex Order 26.4(b)(1)] should have [NJ Ex Order] down in place any time the resident was in bed. LPN/UM #1 confirmed that there was not a PO in the TAR that the nurses could document the placement of the [NJ Ex Order 2] On 4/9/25 at 1:01 PM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted]) who stated residents should have [NJ Ex Order 26.4(b)(1)] in place whenever the resident was in bed. The [U.S. FOIA (b)] further stated that residents should have a PO on the TAR so the nurses could document that the [NJ Ex Order 26.4(b)(1)] were in place. A review of the facility's "Fall Prevention Intervention" policy, revised 4/13/24, included the facility's policy is to ensure residents who have the potential to fall, and /or has a history of falls, they will be identified at the time of admission by way resident history and the nursing fall risk	F 689		

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F 689	Continued From page 25 assessment; Interventions include: Bed and chair alarm, positioning the bed, floor mats at the bedside, low bed and persona; items and call bell within reach of the resident.	F 689		
F 695 SS=D	NJAC 8:39-27.1 (a) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure NJ Ex Order 26.4(b)(1) equipment was stored in an appropriate way to prevent the NJ Exec Order 26.4b1 for 2 of 4 residents (Resident #28 and #57) reviewed for U.S. FOIA (b)(6) care. This deficient practice was evidenced by the following: 1.) On 4/4/25 at 10:31 AM, the surveyor observed that Resident #28 was not in their room. The surveyor observed a NJ Exec Order 26.4b1 was lying directly on the NJ Exec Order 26.4b1 located on the	F 695	1. All NJ Exec Order 26.4b1 for Resident # 28 and Resident #57 that were found on/touching the floor were put in the trash. NJ Exec Order 26.4b1 were cleaned/disinfected and covered appropriately/stored in a plastic bag. New tubing was installed, dated, and stored correctly. Order for Resident #57 was immediately corrected to reflect that NJ Exec Order 26.4b1 . 2. All residents with nebulizers/bi-paps can be effected by this deficient practice. 3. Infection Control Nurse will track oxygen/nebulizer tubing to ensure it is	5/23/25

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F 695	Continued From page 26 bedside table, uncovered and not stored in a plastic bag. The surveyor observed [redacted] not in use lying directly on the floor. On 4/7/25 at 8:15 AM, the surveyor observed Resident #28 awake and alert lying in bed. Resident #28 had an NJ Exec Order 26.4b1 [redacted] NJ Ex Order 26.4(b)(1) [redacted] clean and dry and on room air [redacted]) The surveyor observed the [redacted] lying directly on the NJ Exec Order 26.4b1 located on the bedside table and the [redacted] lying directly on the floor, both uncovered and not stored in a plastic bag. Resident# 28 stated that he/she did not use [redacted] at that time and only received the [redacted] by way of the [redacted]. On 4/8/25 at 10:11 AM, the surveyor observed the [redacted] lying directly on the [redacted] located on the bedside table and the [redacted] lying directly on the floor, both uncovered and not stored in a plastic bag. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to, [redacted] A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident's NJ Exec Order 26.4b1	F 695	dated and in a bag/off the floor, as well as bi-pap machines. All nurses were in-serviced to ensure that oxygen tubing and concentrator bottles must both be dated when changed, as well as when nebulizers are not in use the machine and mask must be stored in a bag. Unit Managers are to review all new orders daily to make sure they were transcribed correctly in EMR. 4. Infection Control Nurse will track weekly for one month, monthly for two months, and then quarterly for 3 months and report to the QA committee for 4 quarters.	

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F 695	Continued From page 27 Further review of the MDS revealed the resident had NJ Exec Order 26.4b1 care and did not use NJ Exec Order 26.4b A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated NJ Exec Order 26.4, that the resident has NJ Exec Order 26 but refuses to wear NJ Exec Order 26.4b. Interventions included: to give medications as ordered physician. A review of the Order Summary Report (OSR), dated as of NJ Exec Order 26.4 included the following physician orders (PO): A PO, dated NJ Exec Order 26, for NJ Exec Order 26 every shift as needed (PRN) at NJ Exec Order 26.4b1) via NJ Ex Order 26.4(b)(NJ Exec Order 26.4b1 to keep NJ Exec Order 26.4b1 or greater as need for NJ Exec Order 26.4b1 . A PO, dated NJ Exec Order 26, for NJ Exec Order 26.4b1 give NJ Exec Order 26.4b1 as needed for NJ Exec Order 26 A review of the NJ Exec Order 26.4b1 Medication Administration Record (MAR) revealed that Resident #28 had received the NJ Exec Order 26.4b1 per physician's order three times a day. A review of the NJ Ex Order 26 and NJ Ex Order 26.4(b)(1) Treatment Administration Record (TAR) revealed that the resident had not used the NJ Exec Order 26 as needed. On 4/8/25 at 11:56 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that when a U.S. FOIA (b)(6) was not in use, the NJ Exec Order 26.4b1 should be stored in a plastic bag. LPN #1 stated	F 695		

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F 695	Continued From page 28	F 695		

that it was important to keep the NJ Exec Order 26.4b1 [redacted], when not in use, in a plastic bag for infection control reasons.

On 4/8/25 at 12:08 PM, the surveyor interviewed LPN #2 who was Resident #28's assigned nurse for that day. LPN #2 stated that when a NJ Exec Order 26.4b1 [redacted] or NJ Exec Order 26.4b1 was not being used, the mask and NJ Exec Order 26 [redacted] should be stored in a plastic bag. At that time, LPN #2 and the surveyor went to Resident #28's room and LPN #2 confirmed that the NJ Exec Order 26.4b1 was not stored in a plastic bag and the NJ Exec Order 26.4b1 was lying directly on the floor and not stored in a plastic bag.

On 4/8/25 at 12:23 PM, the surveyor interviewed the Licensed Practical Nurse Unit Manger (LPN/UM #1) who stated that the NJ Exec Order 26.4b1 [redacted] should be stored in a plastic bag when not being used. LPN/UM #1 further stated that the NJ Exec Order 26.4b1 should not be touching the floor. LPN/UM #1 stated that it was important to store NJ Exec Order 26.4b1 equipment in a plastic bag when not being used so the resident would not get an infection, and dust would not get on the equipment.

On 4/9/25 at 1:06 PM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted] who stated that NJ Exec Order 26.4b1 should not be on the floor and the NJ Exec Order 26.4b1 [redacted] should be stored in a plastic bag when not being used. This was important so that dust, germs or bacteria did not get on the NJ Exec Order 26.4b1.

On 4/10/25 at 12:38 PM, the U.S. FOIA (b)(6) [redacted], in the presence of the U.S. FOIA (b) (6) [redacted], the U.S. FOIA (b) (6) in

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Training (AIT) and the survey team, acknowledged that the NJ Exec Order 26.4b1 should have been stored in a plastic bag when not being used.

2). On 4/4/2025 at 9:50 AM, during the initial tour, the surveyor observed Resident #57 awake and alert, sitting on the bed with NJ Exec Order 26.4b1 infusing at NJ Exec Order 26.4b1). The NJ Exec Order 26.4b1 was connected to a NJ Exec Order 26.4b1 and did not contain a date on NJ Ex Order 26.4(b)(1).

At that time, NJ Exec Order 26.4b1) was observed on the nightstand with the mask uncovered lying on top of the machine.

On 4/7/2025 at 11:52 AM, during a follow-up visit with Resident #57, he/she was alert and awake, sitting upright on the bed, receiving NJ Exec Order 26.4b1 The NJ Exec Order 26.4b1 remained undated. Resident #57 stated that he/she requested that the NJ Exec Order 26.4b1 be changed and was told that the facility did not have the NJ Ex Ord NJ Exec Order 26 that allowed him/her to walk to the bathroom while NJ Ex Order 26.4(b)(1) NJ Exec Order 26.4b. The resident removed the NJ Exec Order 26.4b1 from their NJ Exec Orde to show the surveyor. The NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 were NJ Ex Order 26.4(b)(1) and no longer clear.

At that time, Resident #57 had a NJ Exec Order 26.4b1) on their overbed table. The NJ Exec Order 26.4b1 was lying on

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top of the NJ Exec Order 26.4b1 and was noted to be uncovered and not in use. The resident stated that they used the NJ Exec Order 26.4b1 when they walked to the bathroom and planned to use it shortly.

At that time, the surveyor observed the NJ Exec Order 26.4b1 was again uncovered and lying on the NJ Exec Order 26.4b1 on the resident's nightstand.

A review of the Admission Record, revealed the resident had diagnoses which included but were not limited to, NJ Exec Order 26.4b1 .

A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b1 revealed that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 which indicated the resident's NJ Exec Order 26.4b1 . Further review of the MDS revealed that the resident was on NJ Exec Order 26.4b1

A review of the resident's individual comprehensive care plan (ICCP), dated NJ Exec Order 26.4b1 , included a focus area that the resident had NJ Exec Order 26.4b1 . Interventions included: giving NJ Ex Order 26.4(or NJ Ex Order 26.4(b)(1) as ordered, applying NJ Exec Order 26.4b1 .

A review of the Order Summary Report (OSR), dated as of U.S. FOIA (b)(6), included the following:

A physician's order (PO) dated NJ Ex Order 26.4(b)(1), for continuous NJ Exec Order 26.4b1 for

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NJ Exec Order 26.4b1 every shift.

A PO dated U.S. FOIA (b)(6), to apply NJ Exec Order 26.4b1 settings at bedtime.

The OSR did not include an order to change and date the NJ Exec Order 26.4b1.

On 4/7/2025 at 12:05 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated, the NJ Exec Order 26.4b1 was changed on Wednesdays. LPN #1 further stated the NJ Exec Order2 should be dated when it was changed.

On 4/7/2025 at 12:25 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #2, who stated that the NJ Exec Order 26.4b1 was changed weekly and should be dated when it was changed. LPN/UM #2 further stated that a schedule was posted at the nurses' station indicating when the NJ Exec Order 26.4b1 should be changed. LPN/UM #2 also stated that the NJ Exec Order 26.4b1 should be covered when not used for NJ Exec Order 26.4b1.

At that time, LPN/UM #2 accompanied the surveyor to the resident's room and confirmed that the NJ Exec Order 26.4b1 was undated and that the NJ Exec Order 26.4b1 were uncovered.

On 4/8/2025 at 2:01 PM, the surveyor interviewed the U.S. FOIA (b)(6)), who stated that the NJ Exec Order 26.4b1 should be changed weekly and dated when it was changed.

Further review of the PO revealed an incorrect PO dated NJ Exec Order 26.4b1 (error),

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NJ Exec Order 26.4b1

A review of the U.S. FOIA (b) (6) Review NON PHYSICIAN REPORT (CPRR - a report generated by the U.S. FOIA (b) (6) after reviewing the resident's medications to ensure safe and effective medication therapy) dated NJ Ex Order 26.4(b)(1) indicated no irregularities.

A review of the CPRR dated NJ Exec Order 26.4b1 NJ Ex Order 26.4(b), did not include recommendations regarding NJ Exec Order 26.4b1

On 4/9/2025 at 9:51 AM, the surveyor conducted a follow-up interview with the U.S. FOIA (b) regarding the NJ Ex Order 26.4(b)(order. The U.S. FOIA (b) stated that the order was incorrect and should have indicated that one NJ Exec Order 26 should be given instead of NJ Exec Orde. The U.S. FOIA (b) further stated that the nurse should have immediately clarified the order and called the doctor for any discrepancy.

On 4/10/2025 at 10:16 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that he reviewed each resident's medication regimen every month and sometimes more often. He further stated that the order for NJ Ex Order 26.4(b)(1) was incorrect, and the PO should have been clarified and indicated that NJ should be administered.

A review of the facility's "C-pap/Bi-pap Machine Cleaning and Maintenance" policy, dated 1/4/2018, included that masks should be wiped down daily after each use and place mask in a plastic bag.

A review of the facility's "Infection Control and

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F 695	Continued From page 33 Prevention Program", revised January 6, 2023, included that the program objective was to minimize the risk of transmitting infections associated with the use of procedures, medical equipment and medical devices.	F 695		
F 700 SS=D	N.J.A.C. 8:39- 19.4(a); 27.1(a) Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility documents, it was determined that the facility failed to a.) obtain a	F 700	1. Resident #13 NJ Ex Order 26.4(b)(1) were removed, signed consent from family was obtained for NJ Ex Order 26.4(b)(1)	4/18/25

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	315267	A. BUILDING _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABIGAIL HOUSE FOR NURSING & REHABILITATION	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 700	Continued From page 34 physician's order b.) obtain consent, c.) perform a NJ Ex Order 26.4(b) safety assessment, and d.) follow the facility's policy for NJ Ex Order 26.4(b) assessment and protocol prior to the application of two NJ Ex Order 26.4(b)(and two NJ Ex Order 26.4(b)(1) to a resident's bed. This deficient practice was identified for 1 of 1 resident (#13), reviewed for NJ Ex Order 26.4(b)(1) and was evidenced by the following: On 4/4/25 at 11:15 AM, during the initial tour of the facility, the surveyor observed Resident #13 lying in bed with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 on the resident's bed. When interviewed, the resident stated that he/she used the NJ Ex Order 2 to NJ Ex Order 26.4(b)(1) in bed. The resident was unable to state when the NJ Exec Order 26.4b1 on the bed. On 4/7/25 at 10:31 AM, the surveyor reviewed the medical record for Resident #13. A review of the Admission Record (an admission summary), revealed the resident had diagnoses which included, but were not limited to: NJ Exec Order 26.4b1 A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool	F 700	2. All residents that use side rails may be effected by this deficient practice. 3. Side rail audit has been put in place for all residents, consent forms are being obtained for any resident needing side rails. All staff have been in-serviced that residents should only have top half rails to be used as enablers for repositioning. Staff will observe for injury or entrapment related to side rail use. UM will spot check 10 residents side rails monthly for 3 months and then quarterly for 3 quarters and report to DON/ADON. 4. DON/ADON will report the findings to the QA committee for quarterly 4 quarters.	

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F 700	Continued From page 35	F 700		

used to facilitate the management of care, dated [redacted], included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident's [redacted] and had [redacted] Further review of the the MDS revealed that [redacted] were not coded on the assessment as NJ Ex Order 26.4(b)(1) [redacted]

A review of the resident's individual comprehensive care plan (ICCP) included a focus area, with a revision date of [redacted], that the resident had an ADL (activities of daily living) NJ Ex Order 26.4(b)(1) r/t (related to) [redacted] Interventions included ..[redacted] as per Dr.s order for safety during care provision, to assist with [redacted]. Observe for [redacted] or [redacted] related to [redacted] Reposition Q 2 H (every two hours) and as necessary to avoid [redacted]

A review of the Order Summary Report (OSR) revealed an order dated [redacted], for [redacted] for improved [redacted]. Further review of the OSR revealed that there was no documented evidence of an order for NJ Ex Order 26.4(b)(1) to [redacted] of the resident's bed.

A review of the progress notes failed to include any documentation regarding the resident's use of [redacted].

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A review of a [redacted] Assessment with an effective date of [redacted], included that the use of [redacted] was recommended to provide safety, with [redacted] on both the NJ Ex Order 26.4(b)(1) of the bed, [redacted] were specified. Further review of Rails portion of the assessment included when NJ Ex Order 26.4(b)(1)) were used (Must complete [redacted] Assessment). Further review of the medical record failed to indicate that a [redacted] Assessment was completed as indicated on the [redacted] Assessment form.

On 4/7/25 at 11:18 am, the surveyor observed Resident #13 self-propelling in their wheelchair in the hallway. The surveyor observed that the resident's bed was made and NJ Ex Order 26.4(b)(1) were maintained in the NJ Ex Order 26.4(b)(1).

On 4/8/25 at 10:39 AM, the surveyor observed Resident #13 lying in bed fully dressed with [redacted] on the bed. The resident stated that he/she was waiting for assistance to [redacted]

On 4/8/25 at 10:40 AM, the surveyor observed three Certified Nursing Assistants (CNA) enter Resident #13's room with a NJ Exec Order 26.4b1 [redacted] and closed the door to render care to the resident.

On 4/8/25 at 10:50 AM, the surveyor interviewed CNA #3 who stated that she had worked at the facility for 16 years. CNA #3 stated that Resident #13 had NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 while he/she [redacted] in bed. CNA #3 was unable to state when the NJ Exec Order 26.4b1 . At that

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F 700	Continued From page 37	F 700		

time, the resident had already been assisted [redacted] to the wheelchair and only the [redacted] had been lowered while the [redacted] remaining [redacted] were noted to be maintained in NJ Ex Order 26.4(b)(1) .

On 4/8/25 at 10:58 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated that he worked at the facility for two years. LPN #1 stated that the resident required [redacted] because he/she placed their [redacted] the bed. LPN #1 stated that the resident used the [redacted] to assist themselves and the staff with [redacted] and the [redacted] were not considered [redacted].

On 4/8/25 at 1:04 PM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #2 who stated that the NJ Ex Order 26.4(b)(1) were only placed in the NJ Ex Order 26.4(b)(1) during care for safety. LPN/UM #2 stated that the [redacted] were not [redacted] and were used so that the resident did not roll out of bed. LPN/UM #2 further stated that the NJ Ex Order 26.4(b)(1) should have been [redacted] when the resident was not receiving care.

On 4/8/25 at 1:24 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that the facility did not use [redacted] so she would not code the MDS for [redacted] to be considered as a [redacted] The U.S. FOIA (b)(6) stated that the facility was only permitted to use NJ Ex Order 26.4(b)(1) to promote [redacted] or safety and [redacted] The [redacted] stated that if [redacted] and [redacted] were permitted to be [redacted] simultaneously, that was [redacted], and it was not permitted. The U.S. FOIA (b)(6) stated that she observed the resident quarterly and only saw

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NJ Ex Order 26.4(b)(1) were used to aid in NJ Ex Order 26.4(b) The U.S. FOIA (b)(6) further stated that she reviewed the Care Plans quarterly for new admissions and readmissions and would have expected to see that both NJ Ex Order 26.4(b)(1) and NJ Ex Ord were implemented on the resident's Care Plan because it was part of their care. The MDS stated that there absolutely should have been an order for NJ Ex Order 26.4(b)(1) to be used.

On 4/8/25 at 1:42 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that the facility only used NJ Ex Order 26.4(b)(1) with care to NJ Ex Order 26.4(b)(1) and did not use NJ Ex Order 26.4(b)(1) as a NJ Ex Order 26.4(b)(The U.S. FOIA (b) stated that a physician's order was only necessary for the NJ Ex Order 26.4(b)(1) if the NJ Ex Ord were up all of the time. The U.S. FOIA (b) stated that she would have expected for the use of NJ Ex Order 26.4(b)(to be care planned. The U.S. FOIA (b) stated that the Care Plan was updated as needed, and quarterly. The U.S. FOIA (b) stated that she would check with medical records to determine if a consent was obtained prior to all NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) stated that she was not aware and should have been advised of the implementation of the use of NJ Ex Order 26.4(b)(1) in the daily clinical care meeting. The U.S. FOIA (b) further stated that U.S. FOIA (b)(6) would have put the NJ Ex Order 26.4(b)(1) on the resident's bed.

On 4/8/25 at 2:00 PM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated that he placed both the NJ Ex Order 26.4(b)(1) on the resident's bed to prevent NJ Exec Ord. The U.S. FOIA was unable to state when he put the NJ Ex Order 26.4(b)(1 on the bed. The U.S. FOIA was also unable to provide the surveyor with documented evidence of any requests for NJ Ex Order 26.4(b placement.

On 4/9/25 at 10:20 AM, the surveyor reviewed

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F 700	Continued From page 39 both the resident's electronic health record and paper chart both of which failed to contain a consent for [NJ Ex Order 26.4(b)] usage. The surveyor interviewed LPN/UM #2 at that time, who stated that she was not aware of the facility policy for [NJ Ex Order 26.4(b)] use off of the top of her head. LPN/UM #2 stated that the resident's family member was responsible to sign consent on behalf of the resident when indicated. LPN/UM #2 stated that she would look into the matter further to determine if a consent for [NJ Ex Order 26.4(b)(1)] application was obtained prior to application. On 4/9/25 at 1:32 PM, the surveyor interviewed the [U.S. FOIA (b)] who stated that she would not find a consent in the resident's medical records because the [NJ Ex Order 26.4(b)(1)] should not have been up, because the facility was a [NJ Ex Order 26.4(b)(1)] building. The [U.S. FOIA (b)] stated that she would have expected there to be a signed consent if the [NJ Ex Ord] were in use. On 4/9/25 at 1:44 PM, the surveyor interviewed the [U.S. FOIA (b)(6)]) who stated that the resident had [NJ Ex Order 26.4(b)] for many years, but she had no knowledge of the [NJ Ex Order] being applied to the bed. The [U.S. FOIA (b)(6)] stated that consents were not required when the [NJ Ex Orde] were used for [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA (b)(6)] stated that an order should have been obtained when the [NJ Ex Order 26.4(b)(1)] were added, they should have been added to the care plan and a consent should have been obtained prior to use. The [U.S. FOIA (b)(6)] confirmed that there was never an order, [NJ Ex Order 26.4(b)] safety assessment, consent, or care plan entry for the addition of [NJ Ex Order 26.4(b)(1)] use, or the use of [NJ Ex Order 26.4(b)(1)] to be used simultaneously, but there should have been.	F 700		

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F 700	Continued From page 40 On 4/10/25 at 12:40 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that the NJ Ex Order 26.4(b)(1) had to be removed since there was no order for use. The U.S. FOIA (b)(6) stated that the facility administration did weekly walking rounds inspections of the resident's rooms, but the use of NJ Ex Order 26.4(b)(1) was missed. A review of the facility's "Side Rails Assessment Protocol/Rational" policy reviewed July 2024, included: Residents of this facility, shall have the right to be free from any physical restraint. ...Alternate methods are investigated and side rail usage is determined to be necessary, and side rails meet the definition of a restraint (restricts movement), a physicians' order should be obtained and the side rail should be assessed as an approach to a problem/need on the resident's care plan. If side rails are raised, staff should allow residents the opportunity to toilet and assist with repositioning at least every two hours. However, if residents are independent in bed mobility and have not demonstrated a need to be toileted during the night and are not incontinent, the residents may choose not to be disturbed every two hours while asleep for the purpose of lowering the side rails. Each resident's decision must be documented.	F 700		
F 755 SS=E	NJAC 8:39-27.1 (a) (1)(3)(i) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755		5/16/25

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F 755	Continued From page 41 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to: a.) administer medications according to manufacturers' instructions for 1 of 2 nurses observed during the medication administration pass, b.) ensure the accountability of the narcotic shift to shift count	F 755	1. Nurse #5 and all nurses were in-serviced on proper administration of NJ Exec Order 26.4b1 to Resident #95 and any other resident on NJ Exec Order 26.4b1 Nurse #5 and all nurses were in-serviced on NJ Exec Order 26.4b1 to ensure Resident	

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F 755	Continued From page 42 logs were completed for 1 of 3 medication carts inspected, and c.) complete and maintain copies of Federal narcotic order forms (DEA 222 forms) for 3 of 3 DEA 222 forms reviewed. This deficient practice was evidenced by the following: 1.) On 4/7/25 at 9:20 AM, the surveyor observed Licensed Practical Nurse (LPN) #5 prepare medications for Resident #95. The [redacted] dispensed six medications, including a [redacted]. The LPN poured [redacted] into a medicine cup and administered the medication to the resident without [redacted] When the resident drank the [redacted], he/she [redacted] A review of the Order Summary Report (OSR), dated as of [redacted], included a physician's order for [redacted], with a start date of [redacted]. On 4/7/25 at 11:38 AM, the surveyor interviewed LPN #5 who stated she was not aware of any special instructions for [redacted] but reviewed the bottle of [redacted] which included instructions to '[redacted] Order 26.4b1 The [redacted] then stated she should have mixed the [redacted] with [redacted] On 4/9/25 at 11:26 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated [redacted] should be mixed with juice because it could [redacted] the resident's [redacted].	F 755	#137 and all other residents on [redacted] should be offered water to rinse their mouth after administration. LPN #2, LPN/UM #1, and all nurses were immediately in-serviced on the importance of signing the shift to shift narcotic count log to ensure the count on the medication cart is accurate. 2. All residents have the potential to be effected by this deficient practice. 3. Pharmacy Consultant will do med pass observation for all staff x 1 month followed by 6 staff monthly for 5 months. All nursing supervisors were in-serviced on DEA 222 forms, that copies are kept in the red book in the nursing office, and when medication arrives from the pharmacy the nurse must sign off on the form in the red book that it was received and how many were received with the date they were received. DON/ADON will do spot checks to check compliance. Unit Managers will check narcotic shift to shift report daily and report on it in clinical meeting, Supervisors will check on weekends and report to DON/ADON. 4. DON/ADON will report to the QA for 2 quarters on the 222 forms and the narcotic count log. Pharmacy consultant will report on med pass observation for 2 quarters to the QA committee.	

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F 755	Continued From page 43 On 4/9/25 at 12:28 PM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that NJ Ex Order 26.4(b)(1) could be mixed with water or juice because it "has a taste to it." A review of the manufacturer's instructions for Ferrous Sulfate Elixir, provided by the facility, included directions to "mix with water or fruit juice to avoid NJ Ex Order 26.4(b)(1) ..." A review of the facility's "Administering Medications" policy, undated, included, "Occasionally oral liquid medications must be diluted prior to administration. The specific directions for the individual medication should be followed carefully to prevent untoward effects due to administration of an improperly diluted medication." 2.) On 4/7/25 at 9:40 AM, the surveyor observed LPN #5 prepare medications for Resident #137. The LPN dispensed NJ Exec Order medications, including a [redacted] The LPN donned gloves and administered the NJ Exec Order 26 to the resident without offering the resident NJ Exec Order 26.4b1 his/her NJ Exec Order 26 afterwards. A review of the OSR, dated as of NJ Exec Order 26 included a physician's order for 'NJ Exec Order 26.4b1 [redacted]. On 4/7/25 at 9:50 AM, the surveyor interviewed LPN #5 who stated she was unsure if she was supposed to offer Resident #137 NJ Exec Order 26 after administering the NJ Exec Order 26 but reviewed the NJ Exec Order 26	F 755		

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F 755	Continued From page 44 NJ Exec Order box which included instructions on the label to [redacted] The U.S. FOIA (b) then stated she should have offered water for the resident to rinse his/her mouth because the NJ Ex Order 26.4 could cause NJ Exec Order 26.4b1 [redacted] On 4/9/25 at 11:26 AM, the surveyor interviewed LPN/UM #1 who stated the nurse should instruct the residents to rinse their mouths with water after administering an NJ Exec Order 26.4b1 . On 4/9/25 at 12:28 PM, the surveyor interviewed the CP who stated after administering NJ Exec Order 26. [redacted] the nurse should offer the resident water to rinse their mouth with to U.S. FOIA (b)(6) On 4/9/25 at 1:12 PM, the surveyor interviewed the U.S. FOIA (b) who stated nurses should offer residents water to rinse their mouths after administering NJ Ex Order 26.4(b)(1) to remove any NJ Ex Order 26.4(b) [redacted] in the resident's mouth. A review of the manufacturer's instructions for NJ Exec Order 26.4b1 , provided by the facility, included under Warnings and Precautions, "NJ Exec Order 26.4b [redacted] may occur. Monitor patients periodically. Advise the patient to rinse his/her mouth with water without swallowing after inhalation to help reduce the risk." A review of the facility's "Administering Medications" policy, undated, included, "After administering oral inhalation medications, the resident may experience dry mouth and hoarseness. Gargling and rinsing the mouth with water after each dose may help lessen the discomfort."	F 755		

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	315267	A. BUILDING _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABIGAIL HOUSE FOR NURSING & REHABILITATION	**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 755	Continued From page 45	F 755		

3.) On 4/9/25 at 9:00 AM, the surveyor inspected the A Wing medication cart in the presence of LPN #2 and LPN/UM #1. Upon reviewing the narcotic binder kept on the medication cart (Cart 2), the surveyor observed there were blanks where the nurse did not sign the shift to shift narcotic count log on the following dates:
-4/4/25 7:00 AM Incoming Nurse
-4/4/25 3:00 PM Incoming Nurse
-4/4/25 3:00 PM Outgoing Nurse
-4/4/25 11:00 PM Outgoing Nurse
-4/8/25 11:00 PM Incoming Nurse

On 4/9/25 at 9:17 AM, the surveyor interviewed LPN/UM #1 who acknowledged the omitted signatures on the narcotic shift to shift count log and stated the nurses were supposed to sign the narcotic shift to shift count log every shift to ensure the narcotic count on the medication cart was accurate.

On 4/9/25 at 12:28 PM, the surveyor interviewed the [redacted] who stated the nurses should sign the narcotic shift to shift count log because the nurses were responsible for ensuring the narcotic medications were accounted for.

On 4/9/25 at 1:12 PM, the surveyor interviewed the [redacted] who stated the nurses should sign the narcotic shift to shift count log located on the medication carts every shift.

A review of the facility's "Controlled Substances" policy, dated 4/2024, included, "An inventory of controlled substances retained in each nursing unit must be made at the termination of each shift. This record will be signed by both the outgoing and incoming nurse who meet the

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F 755	Continued From page 46 criteria for handling controlled substances." 4.) On 4/9/25 at 1:45 PM, the [U.S. FOIA (b)(6)] provided copies of the facility's DEA 222 forms for the last year. The following forms did not have "PART 5: TO BE FILLED IN BY THE PURCHASER" filled out which would have indicated the number received and date received for each Schedule I and II [NJ Exec Order 26.4b1] that was ordered by the facility: -Order Form Number: 220095970 dated 3/15/24 -Order Form Number: 220095965 dated 1/23/25 -Order Form Number: 240815653 dated 3/31/25 On 4/10/25 at 8:10 AM, the surveyor interviewed the [U.S. FOIA (b)] who stated the facility did not keep the packing slips when the Schedule I & II [NJ Exec Order 26.4b] [NJ Exec Order 2] were delivered to the facility. On 4/10/25 at 9:51 AM, the surveyor conducted a follow-up interview with the [U.S. FOIA (b)] who stated she was responsible for filling out the DEA 222 forms, but that she only completed PART 1 and PART 2. When asked about the importance of PART 5 of the form, the [U.S. FOIA (b)] stated that it showed the number of narcotic drugs received and the date they were received. The [U.S. FOIA (b)] further stated that PART 5 was to be filled out when the narcotic drugs were received by the facility. The [U.S. FOIA (b)] explained that it was important to fill out PART 5 to prevent drug diversion. On 4/10/25 at 12:00 PM, the [U.S. FOIA (b)] provided the copies of the packing slips for each DEA 222 form and stated she had to obtain the copies from the pharmacy. The [U.S. FOIA (b)] further stated that the facility was not keeping copies of the DEA 222 forms after sending them to the pharmacy, and that the copies provided to the surveyor were also	F 755		

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F 755	Continued From page 47 provided by the pharmacy after surveyor inquiry. The [redacted] explained that the facility did not have the copies of the DEA 222 forms upon receipt of the narcotic drugs to complete PART 5 at that time. A review of the "Instructions for DEA Form 222," located on the back of each DEA 222 Form, included the following: "PART 5. CONTROLLED SUBSTANCE RECEIPT 1. The purchaser fills out this section on its copy of the original order form. 2. Enter the number of packages received and date received for each line item. 3. Purchaser must keep its copy of each executed order form and all copies of unaccepted or defective forms and any attached statements or other related documents available for inspection for a period of two years." NJAC 8:39-27.1 (a) NJAC 8:39-29.7 (c)	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		5/20/25

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F 758	Continued From page 48 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to	F 758	1 U.S. FOIA (b)(6) was notified and discontinued medication immediately for	

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F 758	Continued From page 49 ensure that as-needed (PRN) NJ Exec Order 26.4b1 medications were ordered for no more than 14 days. This was identified for 1 of 5 residents (Resident #40) reviewed for NJ Exec Order 26.4b1 medication use . This deficient practice was evidenced by the following: On 04/10/2025, at 11:35 AM, the surveyor observed Resident #40 sitting quietly and calmly in the day room, smiling. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: NJ Exec Order 26.4b1 [redacted]. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b1 included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 which indicated the resident's NJ Exec Order 26.4b1 [redacted]. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated NJ Exec Order 26.4b1, that the resident is at risk for NJ Ex Order 2 related to U.S. FOIA (b)(6) NJ Ex Orde use. Interventions included: U.S. FOIA (b)(6) to evaluate and attempt NJ Exec Order 26.4b1 as clinically appropriate and U.S. FOIA (b)(6) evaluations as needed. A review of Resident # 40's Physician Order Sheet (POS) included an order with a start date of NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1, give NJ	F 758	Resident #40. 2. Resident #40 and all residents on PRN psychotropic medications have the potential to be effected by this deficient practice. 3. DON/ADON Reviewed with Psychiatrist and all nurses that psych meds should only be ordered for 14 days and must be re-evaluated for use or discontinued after 14 days. All nurses were in-serviced on proper duration of psych meds by DON/ADON. DON/ADON will spot check weekly for a category of an antipsychotic for 4 weeks, monthly for 2 months, and then quarterly for 3 months. 4. DON/ADON will report quarterly to the QA committee for 2 quarters.	

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F 758	Continued From page 50	F 758		

[redacted] as needed for [redacted] The order did not include an end date.

A review of the Medication Administration Record (MAR) for [redacted] revealed that Resident #40 was not administered [redacted].

A review of the [redacted] Review PHYSICIAN REPORT dated [redacted] revealed, "please eval (evaluate) prn [redacted] per CMS (Centers for Medicaid Services) 14 d (day) rule. Suggest order include an end date." It further revealed that the nurse obtained a Telephone Verbal Order (TVO) from the [redacted] that he would evaluate the [redacted] order.

A review of the [redacted] Review PHYSICIAN REPORT dated [redacted] revealed, "please eval (evaluate) prn [redacted] per CMS (Centers for Medicaid Services) 14 d (day) rule. Suggest order include an end date." It further revealed that the nurse obtained a Telephone Verbal Order (TVO) from the [redacted] that he would evaluate the [redacted] order.

On 4/10/2025 at 10:31 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) #1 who stated, that when the resident does not use the PRN (as needed) medication, the nurse would call the [redacted] and inform them that the resident has not been using the medication. He further stated that the doctor would come and speak with the resident, and sometimes, the doctor would discontinue the medication and then reassess the resident in a couple of months.

On 4/10/2025 at 10:33 AM, the surveyor

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F 758	Continued From page 51 interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) # 2, who stated that if the resident is not using the PRN [redacted], the nurse would contact the doctor to see if they want to discontinue the medication and document it in the medical record. The LPN/UM #2 further stated that she would give the [redacted] Review PHYSICIAN REPORT to the [redacted] to decide to continue or discontinue the medication, and a lot of times, the [redacted] would tell the nurse that he would re-evaluate the need for the medication on the next weekly round. On 4/10/2025 at 10:56 AM, the surveyor interviewed the [redacted] who stated that he did not recall seeing the [redacted] PHYSICIAN REPORT dated [redacted] however he was aware of the CMS 14 day rule for PRN [redacted]. He further stated that he believed that when he wrote a PRN order such as [redacted], it would automatically expire after 2 weeks. He also stated that he reviewed the resident's medical record this morning [redacted]) and noted that the resident has not been taking the [redacted] therefore, he does not see any reason why he should be on it and plans to discontinue it. On 4/10/2025 at 11:16 AM, the surveyor interviewed the [redacted]) who stated that if the resident does not use a PRN medication in three to four months the nurse should have called the doctor and have it discontinued. The [redacted] further stated that the PRN [redacted] should have had a 14-day duration in accordance with CMS (Center for Medicare and Medicaid Services) requirements.	F 758		

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F 758	Continued From page 52 A review of the facility's "Psychotropic Usage" undated policy revealed, "PRN psychotropic usage is allowed per CMS regulation if certain documentation is met. All initial prn psychotropics must contain an end date not to exceed 14 days. After 14 days, the prescribers must reassess the resident to renew the medication. Justification is needed in the medical record to document further use. ...There are no exceptions to the above policy for prn psychotropics including residents on hospice." NJAC 8:39-27.1(a)	F 758		
F 759 SS=E	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: REPEAT DEFICIENCY Based on observation, interview, record review, and review other facility documentation, it was determined that the facility failed to maintain a medication error rate of less than 5%. This deficient practice was identified for 2 of 2 nurses on 2 of 3 units ([redacted]Wing and [redacted]Wing) administering medications to 2 of 6 residents (Resident #137 and #231) making 2 errors out of 26 medication opportunities which resulted in a medication error rate of 7%. This deficient practice was evidenced by the	F 759	1. LPN #3 and all nurses were immediately in-serviced by DON/ADON on checking orders for appropriate medication/dosage for Resident #231 and all residents. LPN #5 and all nurses were in-serviced by DON/ADON on ensuring resident #137 has an order to administer their own medication and that physician orders should be followed when administering medications to Resident #137 and any other resident. 2. Resident #231, Resident #137, and all residents have the potential to be effected by this deficient practice.	5/26/25

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F 759	Continued From page 53 following: 1.) On 4/7/25 at 8:30 AM, the surveyor observed Licensed Practical Nurse (LPN) #3 administer medications to Resident #231. The [U.S. FOIA] dispensed [NJ Exec O] medications, including one tab of NJ Exec Order 26.4b1. After administering the medications, the [U.S. FOIA] signed off an order for NJ Exec Order 26.4b1 as administered (Error #1). A review of the Order Summary Report (OSR), as of [NJ Ex Order 26], included a physician's order for [NJ Exec Order] NJ Exec Order 26.4b1 with a start date of [NJ Exec Order 26.4b]. A review of the [NJ Ex Order 26.4(b)(1)] Medication Administration Record (MAR) included the aforementioned order scheduled at 9:00 AM was signed out as administered on [NJ Exec Order 26]. On 4/7/25 at 11:47 AM, the surveyor interviewed LPN #3 who reviewed Resident #231's physician's orders and verified the order was for NJ Exec Order 26.4b1. The [U.S. FOIA] then opened her medication cart and verified there was no NJ Ex Order 26.4(b)(1) in her medication cart. The [U.S. FOIA (6)] stated she should have given the NJ Ex Order 26.4(b)(1) as ordered. On 4/9/25 at 11:26 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated the nurse should check the physician's orders to verify which type of NJ Ex Order 26.4(b)(1) is ordered prior to administration. The LPN/UM explained that if the order was for NJ Exec Order 26.4b1" that it was the [NJ Ex Orde] and that [NJ Exec Order 26.4b1] was the order for NJ Ex Order 26.4(b)(1).	F 759	3. Pharmacy Consultant will do med pass observation monthly. Nurses will be in-serviced upon hire and every six months on medication administration. 4. Pharmacy Consultant will report to the QA committee on med pass observation for 4 quarters.	

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F 759	Continued From page 54 On 4/9/25 at 12:28 PM, the surveyor interviewed the U.S. FOIA (b) (6) for the facility who stated a nurse should not administer NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(if the physician's order was for a NJ Ex Order 26.4(b)(1). On 4/9/25 at 1:12 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated the nurses should check the physician's order to verify which type of NJ Ex Order 26.4(b)(1) to administer so that the resident received the correct medication. 2.) On 4/7/25 at 9:40 AM, the surveyor observed LPN #5 administer medications to Resident #137. The U.S. FOIA (b) dispensed NJ Exec Order 26 medications, including a NJ Exec Order 26.4b1 . After entering the resident's room, the nurse donned gloves and prepared to administer the NJ Exec Order 26.4b1, but the resident took the NJ Exec Order 26.4b1 from the U.S. FOIA (b)(6 hands and administered The resident then asked the U.S. FOIA , "NJ Ex Or , right?" to which the U.S. FOIA acknowledged as correct. After administering Resident #137's medications, the U.S. FOIA signed off the U.S. FOIA (b)(6) order as administered. A review of the OSR, as of 4/7/25, included a physician's order for, NJ Exec Order 26.4b1 ," with a start date o NJ Exec Order 26.4b (Error #2). A review of the NJ Ex Order 26.4(b)(1) MAR included the aforementioned order was scheduled at 9:00 AM was signed out as administered on NJ Ex Order 26.4	F 759		

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On 4/7/25 at 11:38 AM, the surveyor interviewed LPN #5 who reviewed Resident #137's physician's orders and verified the order for NJ Exec Order 26.4b1 was for NJ Exec Order 26.4b1 in NJ Exec Order 26.4b1. The U.S. FOIA (b) then confirmed that only NJ Ex Order 26.4(b)(1) was administered to each NJ Ex Order 26 during the medication pass and stated she should have instructed the resident to administer NJ Ex Order 26.4(b)(1) so that the medication would have the correct effectiveness.

On 4/9/ 25 at 11:26 AM, the surveyor interviewed LPN/UM #1 who stated the nurse should follow the physician's order for the correct number of NJ Exec Order 26.4b1

On 4/9/25 at 12:28 PM, the surveyor interviewed the U.S. FO who stated nurses should be following the physician's order and administer the number of NJ Exec Order 26.4b1 as ordered.

On 4/9/25 at 1:12 PM, the surveyor interviewed the U.S. FOIA (b) who stated the nurses should check the physician's order to verify the correct number of NJ Ex Order 26.4(b)(1) to administer so that the resident received the right dose.

A review of the facility's "Administering Medications" policy, undated, included the following:
"General rules for administering medications
1. Observe the five rights in giving each medication
a. The right resident
b. The right time
c. The right medication
d. The right dose
e. The right method of administration"

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F 759	Continued From page 56 "4. Check the MAR with the label on the medication three times, reading the name of the medication, the route of administration, and the strength of dosage."	F 759		
F 761 SS=E	NJAC 8:39 - 29.2(d) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 761	1. Nurse #3, Nurse #5, and all other	5/2/25

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	315267	A. BUILDING _____ B. WING _____	C 04/17/2025

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F 761	Continued From page 57 and review other facility documentation, it was determined that the facility failed to a.) properly secure medication within the medication cart for 2 of 2 nurses observed during the medication administration pass, and b.) store medications within acceptable temperature ranges for 2 of 3 medication storage areas U.S. FOIA (b)(6)) reviewed for medication storage. This deficient practice was evidenced by the following: 1.) On 4/7/25 at 8:20 AM, the surveyor observed Licensed Practical Nurse (LPN) #3 prepare medications for Resident #30. When the nurse entered the resident's room to administer the resident's medications, she did not lock the medication cart before leaving the medication cart unattended. On 4/7/25 at 8:30 AM, the surveyor observed LPN #3 prepare medications for Resident #231. When the nurse entered the resident's room to administer the resident's medications, she did not lock the medication cart before leaving the medication cart unattended. On 4/7/25 at 9:00 AM, the surveyor observed LPN #3 prepare medications for Resident #232. When the nurse entered the resident's room to administer the resident's medications, she did not lock the medication cart before leaving the medication cart unattended. On 4/7/25 at 9:15 AM, the surveyor interviewed LPN #3 who stated that should have locked the medication cart before leaving it unattended for the residents' safety and to prevent anyone from removing medications from the cart.	F 761	nurses were in-serviced on the importance of locking the medication cart any time it is being left unattended. RN/UM #1, LPN/UM #3, and all other nurses were in-serviced on correct temperatures required for the refrigerators. Medications were disposed of immediately. Maintenance was notified of the issues and corrected the temperatures to the appropriate 36-46 degrees F. 2. All residents have the potential to be affected by this deficient practice. 3. Pharmacy Consultant will continue to do Med Pass observations monthly and will focus on ensuring Nurses are locking medication carts when they are unattended. DON/ADON will spot check during med pass to ensure the carts are locked weekly for 4 weeks then monthly for 4 months. Unit Managers and Supervisors are required to check refrigerator temps daily to ensure they are 36-46 degrees F and to record it on the temperature log and to report anything out of range in clinical meetings. 4. Pharmacy consultant and DON/ADON will report to the QA committee for 2 quarters with their findings.	

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F 761	Continued From page 58 On 4/7/25 at 9:35 AM, the surveyor observed LPN #5 prepare medications for Resident #134. When the nurse entered the resident's room to administer the resident's medications, she did not lock the medication cart before leaving the medication cart unattended. On 4/7/25 at 9:50 AM, the surveyor interviewed LPN #5 who stated she should have locked the medication cart before leaving it unattended to make sure no one could get into the cart. On 4/9/25 at 11;26 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated the nurses should make sure to lock the medication cart before leaving the cart unattended so that no staff, residents, or visitors could go into the cart. On 4/9/25 at 12:28 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated the nurses should ensure their medication carts were locked when unattended because otherwise someone could access the medications. On 4/9/25 at 1:12 PM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated that when the nurses leave their medication carts unattended, they should make sure to lock the cart to prevent anyone from going into the medication cart. A review of the facility's "Storage of Medications in Rooms and Carts" policy, dated 8/2024, included, "Unless ordered by the physician, medications shall be stored in a locked area unless under the supervision of a licensed personnel."	F 761		

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F 761	Continued From page 59	F 761		

2.) On 4/9/25 at 9:17 AM, the surveyor inspected the [redacted] Wing medication room in the presence of Registered Nurse/Unit Manager (RN/UM) #1. Upon opening the medication refrigerator, the surveyor observed the temperature on the thermometer read 26 F (degrees Fahrenheit). Stored in the refrigerator was a vial of Retacrit (a medication used to help make more red blood cells), a bottle of omeprazole (a medication to treat reflux), and three insulin pens. At that time, the RN/UM stated the medication refrigerator should be between 36 F and 46 F, but was unsure the reasoning. The surveyor reviewed the [redacted] Temperature Monitoring Sheet for the medication refrigerator which revealed a recorded temperature of 34 F on 4/2/25 at 6:00 AM.

On 4/9/25 at 9:38 AM, the surveyor inspected the [redacted] medication room in the presence of Licensed Practical Nurse/Unit Manager (LPN/UM) #3. Upon opening the medication refrigerator, the surveyor observed the temperature on the thermometer read 32 F. Stored in the refrigerator were nine bags of insulin pens, two insulin vials, and a COVID-19 vaccine vial. At that time, the LPN/UM stated the medication refrigerator should be between 36 F and 46 F so that the medications did not freeze. The surveyor reviewed the [redacted] Temperature Monitoring Sheet for the medication refrigerator which revealed the following recorded temperatures:
30 F on 4/1/25 at 6:00 AM
30 F on 4/2/25 at 6:00 AM
32 F on 4/3/25 at 6:00 AM
30 F on 4/9/25 at 6:00 AM

On 4/9/25 at 12:28 PM, the surveyor interviewed

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F 761	Continued From page 60 the U.S. FOIA (b)(6) who stated that the medication refrigerator should be kept between 36 F and 46 F because medications could be destroyed at temperatures outside of that range. On 4/9/25 at 1:12 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated the medication refrigerator should be kept between 36 F and 46 F because the medications could go bad if stored at the incorrect temperature. A review of the facility's "Storage of Medications in Rooms and Carts" policy, dated 8/2024, included, "Medications should be kept in the facility in accordance with the manufacturer's guidelines. That is, medications requiring refrigeration should be stored between 36 and 46 degree Fahrenheit ..."	F 761		
F 812 SS=F	NJAC 8:39-29.4(h) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §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 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		5/30/25

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F 812	Continued From page 61 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §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: This is a repeat deficiency. Based on observation, interview, and record review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe consistent manner. This deficient practice was evidenced by the following: On 4/4/25 from 9:39 AM until 10:37 AM, the surveyor observed the following in the presence of the U.S. FOIA (b)(6) 1. The U.S. FOIA (b) lifted the lid of the ice machine to display its contents. The surveyor noted that the ice release cover had multiple areas of brown and gray debris on it. The surveyor asked the U.S. FOIA to wipe the area with a paper towel. The U.S. FOIA wiped the ice release cover and then showed the surveyor the paper towel which was then soiled with a brown substance. The U.S. FOIA (b) stated that if the substance were mold, it would be black, not brown in color. The U.S. FOIA (b) stated that the ice machine was not sanitary and might be unsafe for use. The U.S. FOIA stated that the ice machine should be cleaned every month, but he was unsure when it was last cleaned. There was no maintenance log maintained on the ice machine to demonstrate how frequently it was cleaned. 2. The U.S. FOIA removed the cap from the juice gun which was covered with a brown, moist	F 812	1. The ice machine was cleaned immediately. Juice gun was cleaned immediately by FSD. Cutting boards with deep cuts were disposed of immediately by FSD. Three compartment sink was washed, cleaned, and sanitized. Spices found without a date, or out of date were discarded immediately by FSD. The can opener was disassembled and cleaned immediately by FSD. Undated food was immediately thrown out. All food service staff was in-serviced on sanitation policy and procedure. 2. All residents have the potential to be affected by this deficient practice. 3. Ice machine will be cleaned monthly cleanings logs will be completed by Maintenance and FSD. Juice gun added to cleaning schedule and will be cleaned nightly by closing staff. Cutting boards will be inspected monthly by FSD and AFSD. Any cutting board with nicks/scratched will be removed and discarded immediately. Cutting boards will be replaced as needed. Sanitation bucket will be changed every 4 hours or if there are any visible debris. Quad strips will be used according to company policy to ensure that chemical levels are safe. Sanitation logs will be	

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F 812	Continued From page 62 substance. The [U.S. FOIA (b)] maintained that the juice gun was cleaned last night, and if it were dirty, there would be fruit flies around it. 3. On the drying rack in the Pot Room, the surveyor noted that there were three plastic cutting boards with deep nicks and scratches in them. The [U.S. FOIA] stated, "These are going in the trash." The [U.S. FOIA] further stated that the cutting boards were not safe for use because bacteria could stay on them. 4. In the three compartment sink inside of the Pot Room, the surveyor noted that there were multiple gnats flying out of the drain. The [U.S. FOIA] stated that the three compartment sink was not used, and the pots and pans were washed in the dish machine. 5. In the galley of the kitchen, the surveyor noted a scoop inside of a two gallon container of instant mashed potatoes. The [U.S. FOIA (b)] stated that it was unsanitary to store the scoop directly inside of the container. 6. In the galley of the kitchen, on a shelf below the prep area, there was a bucket of detergent with a rag stored inside of it. The surveyor asked to view the sanitation log for the detergent for the measurement of the sanitation levels. The [U.S. FOIA (b)] stated that he did not keep a log, but then proceeded to demonstrate that the water to detergent ratio was ample for sanitization with the use of a test strip. The [U.S. FOIA] stated that he did not maintain a log, but checked the sanitizer level in the bucket each morning prior to use. 7. In the galley of the kitchen, the surveyor observed an insect that ran across the top of the	F 812	documented by all dietary staff. All pest control problems will be reported to manager on duty, they will be recorded in the pest management book, and reported to the FSD and AFSD. All spices will be checked daily by AFSD/cooks. All spices are labeled and dated with month, opened date, and year. Spices will be kept for one year after received date. Any spice that has reached it's expiration date will be discarded. All food is checked and logged daily by cooks to ensure foods are labeled and dated properly. Food service staff has been in-serviced on sanitation policies and procedures and policy and procedures regarding food storage. All food service staff have also been in-serviced on pest control policy and procedures. The company policies and procedures manual has been revised and updated. 4. Dietitian will complete a kitchen sanitation inspection monthly to keep up with state guidelines. The result of the monthly inspection will be given to LNHA. FSD/AFSD will review all log books weekly for 4 weeks and then monthly x 11 and report to the LNHA. Administrator will report to the QA committee quarterly for 4 qaurters.	

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F 812	Continued From page 63 stove. The [U.S. FOIA] stated that it was a fruit fly. 8. On the second shelf of a five tiered wired rack, an opened packet of one pound chicken base was noted. The [U.S. FOIA] stated that the packet should not have been stored opened because insects and bacteria could get inside of the packet. The [U.S. FOIA (B)] then proceeded to take the opened packet of chicken base to the food preparation area in the galley of the kitchen where he indicated it would be used to prepare the luncheon meal. 9. On the top shelf of a five tiered wired rack, a two pound container of thyme with a received date of 6/22, had an opened date of 6/1, with no year indicated on the label. And a two pound container of cilantro with a received date of 6/22 had a checked date of 12/31, with no year specified. The [U.S. FOIA] stated that spices were good for two to three years after opening. The [U.S. FOIA] stated that he did not have a policy for the shelf life of spices after opening. 10. In the walk-in refrigerator, a rolling cart had four trays of canned pears that were stored in individual clear plastic containers, that were not labeled or dated. 11. On the second shelf of a three-tiered wired rack, an opened eight ounce container of salsa was not labeled or dated. The [U.S. FOIA] stated that it was from the last taco Tuesday and should have been dated so that you knew when it expired. 12. On the second shelf of a three-tiered wired rack, a hotel pan of cooked breakfast sausage links were not labeled or dated. The [U.S. FOIA (B)] stated that they were left over from this morning and	F 812		

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F 812	Continued From page 64 should have been labeled and dated. 13. In the dry storage room, there were two ten pound containers of sugar and flour and both of the containers had their scoops stored directly inside of the bins. The [U.S. FOIA (b)] stated that the scoops should not have been stored inside of the bins for sanitary reasons. 14. Inside of the ice cream freezer, there was no thermometer present, and there was no temperature log to indicate when the temperature was last checked. The ice cream was hard to touch, but there was water running down the back of the freezer wall. The [U.S. FOIA] stated that he wanted to ensure that the ice cream was hard, and was not melted. 15. In the galley of the kitchen, the [U.S. FOIA] pulled the table mounted can opener from its' sheathe and the exposed the can opener blade that had a dried, brown debris on it. The [U.S. FOIA] stated that it was important to clean the can opener after use or the debris may get in the food. 16. In the galley of the kitchen, there was a soiled two-tiered rolling rack with scoop dishes and bowls on it in the tray line area. The bowls had solid, black debris on them. The [U.S. FOIA (b)(6)] stated that the rolling cart should have been cleaned after the breakfast meal. On 4/8/25 at 8:40 AM, the surveyor interviewed the [U.S. FOIA (b)(6)] who stated that he cleaned the ice machines in the facility on a quarterly basis, but he cleaned the ice machine more frequently in the kitchen, and documented it on a piece of paper in his own records the day	F 812		

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F 812	Continued From page 65 that it was completed. The [U.S. FOIA] stated, "they told me there was mold in there". The [U.S. FOIA] stated, "from what I know, you can get sick from it, and I would not drink it." The [U.S. FOIA] stated that the facility informed him verbally that the ice machine was dirty prior to him cleaning it. On 4/10/25 at 12:35 PM, in the presence of the survey team the surveyor informed the [U.S. FOIA (b)(6)] of all concerns related to the kitchen observations. The [U.S. FOIA (b)(6)] stated that the [U.S. FOIA] reported directly to him and he was responsible to provide oversight over the kitchen. The [U.S. FOIA (b)(6)] stated that the [U.S. FOIA] had to clean the ice machine more frequently and keep a log of it. A review of the facility policy "Food Storage And Handling Policy" undated, included: Dry food and food supplies shall be stored in a clean, dry location not exposed to splash, dust, or other contamination. ...Food packages shall be in good condition and protect the integrity of the contents so that the food is not exposed to adulteration or potential contaminants. ...Food inventories shall be rotated on a first-in, first-out (FIFO) basis. Each product shall be marked with date of entry and expiration date. ...The temperature of all freezer units shall be kept at 0 F (Fahrenheit) or lower. ...Temperatures shall be monitored in all refrigeration and freezer units, checked daily (or more often if there is a problem), and recorded...	F 812		

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F 812	Continued From page 66 ...All food-contact equipment and utensils shall be stored in a sanitary manner. ...Food Service Equipment shall be: ...Kept clean and free of debris, breaks, open seams, cracks, chips, pits, inclusions, or similar imperfections...Kept in good repair and in operation. Any equipment not in use shall be removed, repaired, or replaced. ...Cutting boards and blocks shall be made from plastic washable materials or hard maple that is not absorbent, meets all code requirements, and is free of seams and cracks...Cutting boards should be replaced when boards become excessively worn or develop hard-to-clean grooves... NJAC 8:39-17.4	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(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(h) Medical records. §483.70(h)(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		5/5/25

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F 842	Continued From page 67 (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services	F 842		

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	315267	A. BUILDING _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABIGAIL HOUSE FOR NURSING & REHABILITATION	**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 842	Continued From page 68 provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review other facility documentation, it was determined that the facility failed to ensure residents' records were kept confidential for 3 of 6 residents (Resident #30, #231, and #232) observed during the medication administration pass. This deficient practice was evidenced by the following: On 4/7/25 at 8:20 AM, the surveyor observed Licensed Practical Nurse (LPN) #3 prepare medications for Resident #30. When the nurse left the medication cart to administer the resident's medications, she did not put up a privacy screen to cover the resident's record displayed on the nurse's laptop. On 4/7/25 at 8:30 AM, the surveyor observed LPN #3 prepare medications for Resident #231. When the nurse left the medication cart to administer the resident's medications, she did not put up a privacy screen to cover the resident's record displayed on the nurse's laptop. On 4/7/25 at 9:00 AM, the surveyor observed LPN #3 prepare medications for Resident #232. When the nurse left the medication cart to	F 842	1. LPN #3 and all Nurses were immediately in-serviced by U.S. FOIA (b)(6) on the need for putting up a privacy screen on their laptop when they are leaving the medication cart to ensure medical records privacy. Confidentiality of Resident #30, Resident # 231, Resident #232 and all other residents information/records was reviewed with all nursing staff by DON/ADON. 2. All residents have the potential to be affected by this deficient practice. 3. Pharmacy Consultant will continue to do Med Pass observations/competencies to ensure privacy screens are in place when nurses leave medication carts unattended. DON/ADON will spot check during med pass to ensure the carts are locked weekly for 4 weeks then monthly for 4 months. 4. Pharmacy consultant and DON/ADON will report to the QA committee for 2 quarters with their findings.	

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F 842	Continued From page 69 administer the resident's medications, she did not put up a privacy screen to cover the resident's record displayed on the nurse's laptop. On 4/7/25 at 9:15 AM, the surveyor interviewed LPN #3 who stated that should have put up the privacy screen when she left her medication cart unattended to protect the residents' privacy. On 4/9/25 at 11;26 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated the nurses should make sure the privacy screen was on when they leave their medication cart unattended so that no one could read the residents' information on the laptop. On 4/9/25 at 1:12 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that when the nurses leave their medication carts unattended, they should make sure to turn on the privacy screen so that no one sees the residents' information. A review of the facility's "Confidentiality of Medical Records," policy, dated 8/2024, included, "It is the policy of Abigail House to respect and protect resident's rights to confidentiality of clinical and personal information."	F 842		
F 880 SS=D	NJAC 8:39-4.1 (a)(18) 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	F 880		5/12/25

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F 880	Continued From page 70	F 880		

comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§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 §483.71 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

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F 880	Continued From page 71 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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, and review of facility documents, it was determined that the facility failed to maintain proper infection control practices to ensure: a.) kitchen staff performed hand hygiene at the appropriate times and adhered to proper food handling procedures during the tray line observation b.) staff performed appropriate hand hygiene during meal service for 1 of 3 dining rooms observed (A Wing). This deficient practice was evidenced by the following: 1. On 4/9/25 at 12:16 PM, during a follow-up visit to the kitchen to observe the lunch meal tray line	F 880	1. Hand Hygiene in-service given and competencies were done by Infection Preventionist with all staff, including return demonstration. 2. All residents have the potential to be affected by this deficient practice. 3. Hand hygiene in-services/competencies will be done monthly for 6 months with staff followed by routine surveillance monthly for six months by IP. 4. IP will report to the QA committee for 4 quarters	

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F 880	Continued From page 72 service, the surveyor observed Cook #1 who washed her hands at the handwashing sink for 21 seconds. Cook #1 then proceeded to donn (put on) a pair of gloves prior to preparing to obtain food temperatures from the steam table. Cook #1 placed several scoops and ladles in direct contact with the surface of the preparation area of the steam table. As Cook #1 proceeded to obtain food temperatures, her right arm brushed up against the scoops and ladles which caused them all to fall onto the floor. At 12:25 PM, the U.S. FOIA (b)(6)) observed the scoops and ladles that laid on the floor and directed Cook #1 to pick them up and run them through the dish washer. Cook #1 picked up the scoops and ladles with her gloved hands and took them over to the dish washer to be cleaned. Cook #1 then proceeded to doff (remove) her gloves and donned clean gloves without first performing hand hygiene. At 12:32 PM, Cook #1 began plating food. At 12:37 PM, Cook # 1 was observed using her right gloved hand to move a sausage and oven roasted potatoes around on the plate in order to redistribute the food. At 12:45 PM, the U.S. FOIA accompanied the surveyor and observed Cook #1 who continued to use her right gloved hand to move both sausages and potatoes around on the plate in order to accommodate additional food items that were added to the plates. At that time, the U.S. FOIA stated that Cook #1 should have washed her hands after she doffed her gloves and before donning new gloves prior to plating food. The U.S. FOIA stated that there was a concern for contamination.	F 880		

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F 880	Continued From page 73 On 4/9/25 at 12:52 PM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated that hand hygiene should occur after you doff your gloves. The [redacted] further stated that there was a concern for contamination if Cook #1's hands were not washed after she touched the soiled utensils and then touched food on the tray line. On 4/9/25 at 1:20 PM, the surveyor interviewed Cook #1 who stated that she should have washed her hands after she doffed her gloves and before she donned new gloves and started plating food on the tray line. Cook #1 further stated that if she failed to wash her hands and then touched food with her gloved hands it may result in food borne illness or contamination. On 4/10/25 at 12:35 PM, in the presence of the survey team the U.S. FOIA (b)(6)) was made aware of the surveyors findings. 2. On 4/9/25 at 12:48 PM, the surveyor observed the lunch meal service in the [redacted] Wing dining room. At that time, the surveyor observed Certified Nursing Assistant (CNA) #1 touch Resident#382's slice of white bread, and then proceeded to place the meat inside of the slice of bread and folded the bread over to make a sandwich with her ungloved hands. CNA # 1 then obtained a tray from the lunch cart and served the lunch tray to Resident # 100 without first performing hand hygiene. On 4/10/25 at 09:19 AM, the surveyor interviewed CNA #2 who stated that when assisting residents at mealtime "you don't touch the food with bare hands."	F 880		

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F 880	Continued From page 74 On 4/10/25 at 09:23 AM, The surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) #1 for [redacted] Wing who stated that when CNAs are assisting residents during meal service, the CNAs should wear gloves when touching a resident's food and should not touch food with their bare hands. The LPN/UM #1 further stated that the staff should perform hand hygiene between serving meal trays to each resident. On 4/10/25 at 10:09 AM, the surveyor interviewed CNA #1 who confirmed that she was the CNA who assisted Resident #382 and Resident #100 with their lunch trays the previous day. CNA #1 stated that hand hygiene should be performed before and after assisting a resident with their meal tray and "you don't touch residents' food with your bare hands." On 4/10/25 at 10:51 AM, the surveyor interviewed the [redacted]) who stated that hand hygiene should be performed before and after serving a resident their meal tray. The [redacted] further stated that a staff member should not use their ungloved (bare hands) to touch a residents' food. The [redacted] stated that the staff should have worn gloves when touching a resident's food and this was important so that you do not pass any germs on to the resident. A review of the facility's "Food Storage and Handling", undated, included: All employees shall ensure proper hand-washing techniques are used...If food servers' hands must be in direct contact with food, the <designated person> shall ensure food servers are wearing single-use gloves.	F 880		

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F 880	Continued From page 75 A review of the facility's "Handwashing" policy, review date 2/2025, included: employees must thoroughly wash their hands when: ... before handling food/medications ... And including: immediately before touching a resident,...after touching a resident or the resident's immediate environment ..., immediately after glove removal....	F 880		
F 881 SS=D	NJAC 8:39-19.4(n) Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and review of other pertinent facility documentation, it was determined that the facility failed to ensure full implementation of the [NJ Exec Order 26.4b1] stewardship program, including ongoing monitoring and use of a nationally recognized surveillance criteria when [NJ Exec Order 26.4b1] were being prescribed. This deficient practice was identified for 3 of 3 residents (Resident #50, #78, and #124) reviewed for [NJ Exec Order 26.4b1] stewardship. This deficient practice was evidenced by the following:	F 881	1. [U.S. FOIA (b)(6)] form was filled out completely for each [NJ Exec Order 26.4b1] for Resident #50, Resident #78, Resident #124 and any other resident that is on an [NJ Exec Order 26.4b1]. All nurses and [U.S. FOIA (b) (6)] were in-serviced by DON/ADON on this deficient practice. 2. All residents have the potential to be affected by this deficient practice. 3. A McGreer's form is filled out for each anti-biotic initiated within the facility. DON/ADON will spot check the anti-biotic	5/6/25

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F 881	Continued From page 76 On 4/9/2025 at 11:04 AM, the surveyor interviewed the U.S. FOIA (b)(6) regarding the facility's Antibiotic Stewardship Program (efforts to ensure that antibiotics are used only when necessary and appropriate). The [redacted] stated that she had worked at the facility full-time since February 24, 2025. The [redacted] stated that she used the [redacted] criteria (clinical and laboratory findings used to define and track infections in long-term care facilities). At that time, the surveyor reviewed the [redacted] Checklist (a list of residents prescribed antibiotics). The [redacted] checklist indicated the following: Resident #50 was prescribed [redacted] for a NJ Exec Order 26.4b1 [redacted], and he/she met the criteria for [redacted]. Resident #78 was prescribed [redacted] for a [redacted], and he/she met the criteria for [redacted]. Resident #124 was prescribed an [redacted] for NJ Exec Order 26.4b1 [redacted] and he/she met the criteria. When the surveyor asked the [redacted] how she determined that the resident met the criteria, she stated that she was aware of the requirements. The [redacted] further stated that she had no documented evidence of the [redacted] Criteria Assessment usage and had not completed the assessment form since she started working there. On 4/10/25 at 12:23 PM, the surveyor interviewed	F 881	stewardship binder for the McGreer's form monthly for 6 months. 4. DON/ADON will report the findings to the QA committee for 2 quarters.	

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F 881	Continued From page 77 the [redacted]) in the presence of the survey team, who stated that the [redacted] Criteria for Infection Checklist should have been completed for each resident to ensure that the resident met the criteria for antibiotic usage. A review of the facility's "Antibiotic Stewardship" policy, reviewed 9/2024 revealed: "POLICY: To promote appropriate use of antibiotics, while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotics use." NJAC 8:39-19.4(c) (d)	F 881		

New Jersey Department of Health

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	060418	A. BUILDING: _____ B. WING _____	C 04/17/2025

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S 000	Initial Comments The facility is 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 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, interviews, and review of pertinent facility documentation, 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 deficient practice was evidenced by the following: 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	S 560	1. In-serviced Staffing Coordinator and Supervisors on proper Staffing Ratios for each shift to ensure we are fully staffed. 2. All residents have the potential to be affected by this deficient practice. 3. Staffing schedule is reviewed by DON/ADON at the beginning and end of their shift each day, including the weekend on Fridays. Supervisors also review the staffing schedule at the beginning and end of their shifts. Text message shift alerts are used to text staff to alert them of available shifts that need to be filled, in	5/9/25

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

Electronically Signed | 05/09/25

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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer 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 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. For the 2 weeks of staffing prior to survey from 3/16/25 to 3/29/25, the facility was deficient in CNA staffing for residents on 9 of 14 day shifts as follows: -03/16/25 had 21 CNAs for 179 residents on the day shift, required at least 22 CNAs. -03/17/25 had 21 CNAs for 179 residents on the day shift, required at least 22 CNAs. -03/18/25 had 21 CNAs for 179 residents on the day shift, required at least 22 CNAs. -03/21/25 had 22 CNAs for 182 residents on the day shift, required at least 23 CNAs. -03/22/25 had 20 CNAs for 182 residents on the day shift, required at least 23 CNAs. -03/23/25 had 20 CNAs for 182 residents on the day shift, required at least 23 CNAs. -03/24/25 had 22 CNAs for 182 residents on the day shift, required at least 23 CNAs. -03/26/25 had 22 CNAs for 182 residents on the day shift, required at least 23 CNAs.	S 560	advance, as well as when call outs occur. Staff in facility are asked if they are willing to work overtime. Several Staffing agencies are also contacted to fill in shifts when needed. We brought back another staffing agency that had stopped sending staff to help with our needs. 4. DON/ADON Will report results to the QA committee for 2 quarters to determine any further interventions	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060418	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABIGAIL HOUSE FOR NURSING & REHABILITA	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) COMPLETE DATE
S 560	Continued From page 2 -03/29/25 had 20 CNAs for 184 residents on the day shift, required at least 23 CNAs. On 4/10/25 at 10:22 AM, the surveyor interviewed the Staffing Coordinator (SC) who stated that the mandated direct care staffing ratios were 1:8 on day shift, 1:10 on evening shift and 1:14 on night shift. The SC stated that to ensure the facility meets the mandated requirements, the facility used as needed (prn) staff nurses, and agency. On 4/10/25 at 11:05 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the required minimum direct care staff-to-resident ratios were one CNA to eight residents on the day shift, one CNA to ten residents on the evening shift, and one CNA to fourteen residents on the night shift. The DON further stated that the facility followed state regulations in order to determine the staffing levels needed to meet each resident's needs. A review of the facility's "Staffing Guidelines" policy, reviewed 4/2024, included that staffing levels are assessed daily(by shift) and adjustments are made for staff assignments based on patient/resident acuity and care needs.	S 560		
S2345	8:39-31.6(o) Mandatory Physical Environment The facility shall conduct at least one evacuation drill each year, either simulated or using selected residents. State, county, and municipal emergency management officials shall be invited to attend the drill at least 10 working days in advance.	S2345		5/9/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S2345	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and interview on 4/17/25 in the presence of the Administrator, it was determined the facility failed to invite State, county and municipal emergency management officials to attend at least 1 evacuation drill in the last 12 months. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review of the facility's emergency preparedness documents revealed there was no documentation of the State, county and municipal Office of Emergency Management (OEM) officials being invited to or attending a full scale evacuation drill at the facility in the last 12 months. In an interview at 1:57 PM, the Administrator confirmed the record review and stated the facility did not invite OEM to the drills this year. The facility's Administrator, the Director of Nursing and the Assistant Director of Nursing were informed of the deficient practice at the Life Safety Code exit conference at 2:46 PM.	S2345	1. No residents have been affected by this practice. Facility conducted a disaster drill on 5/8/2025 in the presence of the Fire marshal and the local OEM officials. 2. All residents have the potential to be affected by this practice. 3. Maintenance Director was in-serviced on the need to invite State, County, and local emergency management officials to attend the drills. 4. Maintenance Director will report to the QA committee every six months in regards to disaster drills for the next 4 quarters.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315267 Y1	A. Building B. Wing Y2	6/4/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ABIGAIL HOUSE FOR NURSING & REHABILITATION	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 F0569	Correction	ID Prefix F0576	Correction	ID Prefix F0584	Correction
Reg. # 483.10(f)(10)(iv)(v)	Completed	Reg. # 483.10(g)(6)-(9)	Completed	Reg. # 483.10(i)(1)-(7)	Completed
LSC	05/02/2025	LSC	05/05/2025	LSC	05/07/2025
ID Prefix F0622	Correction	ID Prefix F0657	Correction	ID Prefix F0658	Correction
Reg. # 483.15(c)(1)(i)(ii)(2)(i)-(iii)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	04/30/2025	LSC	05/23/2025	LSC	04/18/2025
ID Prefix F0689	Correction	ID Prefix F0695	Correction	ID Prefix F0700	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.25(n)(1)-(4)	Completed
LSC	04/18/2025	LSC	05/23/2025	LSC	04/18/2025
ID Prefix F0755	Correction	ID Prefix F0758	Correction	ID Prefix F0759	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(c)(3)(e)(1)-(5)	Completed	Reg. # 483.45(f)(1)	Completed
LSC	05/16/2025	LSC	05/20/2025	LSC	05/26/2025
ID Prefix F0761	Correction	ID Prefix F0812	Correction	ID Prefix F0842	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.20(f)(5), 483.70(h)(1)-(5)	Completed
LSC	05/02/2025	LSC	05/30/2025	LSC	05/05/2025

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315267 Y1	A. Building B. Wing Y2	6/4/2025 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0880	Correction	ID Prefix F0881	Correction		
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80(a)(3)	Completed		
LSC	05/12/2025	LSC	05/06/2025		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
4/17/2025	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060418 Y1	A. Building B. Wing Y2	6/4/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ABIGAIL HOUSE FOR NURSING & REHABILITATION	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 Reg. # 8:39-5.1(a) LSC	Correction Completed 05/09/2025	ID Prefix S2345 Reg. # 8:39-31.6(o) LSC	Correction Completed 05/09/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 4/17/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315267	A. BUILDING **01** B. WING _____	**04/17/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABIGAIL HOUSE FOR NURSING & REHABILITATION	**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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 04/16/25 and 4/17/25 and Abigail House 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. 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 has nine smoke zones. The facility had 178 occupied beds of the 188 licensed beds at the time of the LSC survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/08/2025

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 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and	K 222		4/18/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315267	A. BUILDING 01 B. WING _____	04/17/2025

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K 222	Continued From page 2 ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/16/25 in the presence of the U.S. FOIA (b)(6) , it was determined the facility failed to ensure doors in a required means of egress were not equipped with a lock or latch in accordance with NFPA 101: 2012 Edition, Section 7.2.1, 7.2.1.5.3, 7.2.1.6.1 and 19.2.2.2.4. This deficient practice has the potential to affect all residents and was evidenced by the following: Observations at 10:20 AM of the front main entrance/exit revealed 2 sets of automatic sliding double doors with instructional signs on each door that stated IN EMERGENCY PUSH TO OPEN. The outer set of double doors was equipped with a thumb latch lock in the path of egress to exit the building.	K 222	1. Residents were not affected as the front sliding door is not locked. The Front Desk is monitored 24/7. The thumb latch lock was immediately removed. 2. All residents have the potential to be affected by this deficient practice. All exit doors are clear and free of thumb latch locks and all locks. 3. U.S. FOIA (b) (6) was in-serviced by AIT. All exit doors will be checked monthly for six months by maintenance to ensure there are no locks on exit doors other than the buildings mag lock system. 4. Maintenance director will report to Q.A.	

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	315267	A. BUILDING 01 B. WING _____	04/17/2025

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K 222	Continued From page 3 In an interview at the time, the U.S. FOIA (b)(6) [redacted] confirmed the observation. The facility's Administrator, the U.S. FOIA (b)(6) [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 4/17/25 at 2:46 PM.	K 222	committee on a quarterly basis for the next 2 quarters.	
K 271 SS=D	N.J.A.C 8:39-31.2 (e) Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation, interview on 4/16/25 and 4/17/25 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined the facility failed to maintain a stable, level walking surface at exit discharge for 1 of 14 exterior exits in accordance with NFPA 101: 2012 Edition, Section 7.7, 7.1.6.2, 7.1.10.1, 19.2.7. This deficient practice has the potential to affect 43 residents and was evidenced by the following: Observations on 4/17/25 at 9:00 AM revealed the paver walk from the courtyard to the public way (parking lot) posed a trip hazard in the path of egress for evacuation. The pavers were raised up	K 271	1. No residents have been affected as this is used only as an emergency exit path. Paver stones were removed, ground was leveled, roots leveled and paver stones reset. 2. All C-Wing residents have the potential to be affected by this deficient practice. Maintenance Director surveyed facility property and confirmed there are no other stone paths to pose a hazard nor are there any tripping hazard at this time. 3. U.S. FOIA (b)(6) [redacted] was educated	5/21/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315267	A. BUILDING 01 B. WING _____	04/17/2025

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K 271	Continued From page 4 in two locations along the path. In an interview on 4/17/25 at 11:29 AM, the U.S. FOIA (b)(6) confirmed the observation. The facility's Administrator, the U.S. FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference on 4/17/25 at 2:46 PM. N.J.A.C 8:39-31.2 (e)	K 271	by Administrator in Training to inspect all paths. Director of Maintenance will inspect path quarterly to ensure there are no trip hazards. 4. Director of Maintenance will report to Quality Assurance committee on a quarterly basis for a period of Four quarters.	
K 341 SS=F	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 observation and interview on 4/16/25 in the presence of the U.S. FOIA (b)(6)	K 341	1. No residents were affected. A smoke detecting device was installed near the	4/18/25

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K 341	Continued From page 5 U.S. FOIA (b) it was determined the facility failed to ensure that automatic smoke detection was provided at all Fire Alarm Control Unit's (FACU), in accordance with NFPA 101: 2012 Edition, Sections 19.3.4.1, 9.6.1.8 and NFPA 72: 2010 Edition, Section 10.15. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations at 10:22 AM of the FACU mechanical room revealed the room was not an occupied room and was not equipped with a smoke detector to protect the FACU. In an interview at the time, the U.S. FOIA (b)(6) confirmed the observation. The facility's U.S. FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference on 4/17/25 at 2:46 PM. N.J.A.C 8:39-31.2 (e)	K 341	Fire Alarm Control Unit the following day. 2. All residents have the potential to be affected by this practice. 3.U.S. FOIA (b)(6) has been In serviced by Administrator that every/any unoccupied area needs to be equipped with a smoke detecting device. 4.Director of Maintenance will check monthly to make sure every unoccupied area has a smoke detecting device and will report to QA quarterly for 2 quarters.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____	K 353		5/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315267	A. BUILDING 01 B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABIGAIL HOUSE FOR NURSING & REHABILITATION	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
K 353	Continued From page 6 b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 4/16/25 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined the facility failed to ensure fire sprinklers and their components were inspected and maintained in accordance with NFPA 101: 2012 Edition, Section 9.7 and NFPA 25: 2011 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations during a facility tour between 10:19 AM and 1:25 PM revealed: 1. In the fire alarm panel room, the ceiling tiles were missing along back wall which would allow smoke and hot gases to go into the space above and interfere with the fire sprinkler activation. 2. In the A wing janitors closet, a ceiling tile was missing by the sprinkler head. 3. In the kitchen pantry dry storage room, the escutcheon was missing on 1 of 2 sprinkler heads. 4. In the side hall to an exit by the kitchen above the electrical panels, there were openings where conduit and wires penetrated the drop ceiling in 9 places.	K 353	1. No resident were affected. All missing ceiling tiles were replaced. Any penetrations were sealed with Fire rated materials. All escutcheons that were not at correct height have been raised. All missing escutcheons have been replaced. All sprinkler heads that were rusted have been replaced. All dusty sprinkler heads have been cleaned. 2.All Residents have the potential to be affected by this practice 3.U.S. FOIA (b)(6) [redacted] was in-serviced by AIT. Director of Maintenance/designee will start with bi-weekly rounds inspecting all sprinklers, escutcheons and ceiling tiles for 1 quarter and then monthly for the following 3 quarters. 4. Director of Maintenance will report to the QA committee quarterly for the next 4 quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315267	A. BUILDING 01 B. WING _____	04/17/2025

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K 353	Continued From page 7 In interviews at the times, the U.S. FOIA (b)(6) [redacted] confirmed the observations. 5. In the main hall janitors closet across from smoking area, the sprinkler head was missing it's escutcheon. 6. In the maintenance shop, five of 12 sprinkler heads were rusted and had excessive dust. 7. In the laundry, two sprinklers behind the dryers and 1 sprinkler by the washer were dusty. 8. In the medical records room, one of 6 sprinkler head escutcheon was down 2-inches from its designed place. 9. In the C wing storage room next to the soiled linen room, the sprinkler head was missing it's escutcheon. 10. In the two B wing shower rooms there were sprinkler heads in each room that had their escutcheons down 1-1/2 inches from their proper place. 11. In the MDS coordinators room, one of 4 sprinkler heads was missing it's escutcheon. 12. In the nurses office, one of 2 sprinkler heads had an escutcheon missing. 13. In the therapy kitchen area, a sprinkler head had an escutcheon missing. In interviews at the times, the ADM confirmed the observations.	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315267	A. BUILDING 01 B. WING	04/17/2025

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

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K 353	Continued From page 8 The facility's U.S. FOIA (b) (6) the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) were informed of the deficient practice at the Life Safety Code exit conference on 4/17/25 at 2:46 PM. N.J.A.C 8:39-31.2 (e) NFPA 25	K 353		
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/16/25 in the presence of the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6)), it was determined the facility failed to ensure that Class K portable fire extinguishers were provided with the required instructional placard in accordance with NFPA 101:2012 Edition, Sections 9.7.4 and NFPA 10:2010 Edition, Sections 5.5.5.3, A 5.5.5.3. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:00 AM revealed that the Class K fire extinguisher in the kitchen was not provided with the required instructional placard stating that the fire protection system shall be actuated prior to using the class K-type portable fire extinguisher.	K 355	1. No residents were affected. Director of Maintenance placed an instructional placard stating to use the fire protection system prior to using the fire extinguisher. 2. All residents have the potential to be affected by this deficient practice. 3. U.S. FOIA (b) (6) was in-serviced by Administrator for the need of an instructional placard prior to using a K-Type fire extinguisher. Director of Maintenance /designee will inspect fire extinguishers bi-weekly to ensure the instructional placard is present for the next 2 quarters followed by monthly for the next 2 quarters. 4. Director of Maintenance will report the	4/18/25

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K 355	Continued From page 9 In an interview at the time, the U.S. FOIA (b)(6) confirmed the observation. The facility's U.S. FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference on 4/17/25 at 2:46 PM. N.J.A.C 8:39-31.1 (c), 31.2 (e) NFPA 10, 96	K 355	bi-weekly and monthly audits to QA committee quarterly for the next 2 quarters	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 4/16/25 in the presence of the U.S. FOIA (b)(6)), it was determined the facility failed to ensure that electrical panels were guarded to prevent unauthorized access, tampering, or potential hazards in resident accessible areas in accordance with NFPA 101: 2012 Edition, Section 19.5.1, 19.5.1.1, 9.1, 9.1.2, NFPA 99: 2012 Edition, Section 6.3.2.1, 6.3.2.2.1.3 (A), 15.5.1.2 and NFPA 70: 2011 Edition, Section 110.26, 110.27 and 110.16. This deficient practice had the potential to affect all residents and was evidenced by the following:	K 911	1. No residents were affected. Director of Maintenance checked and locked all Breaker panels. Which includes A-wing, B-wing, C-wing and the service corridor by the kitchen. 2.All Residents have the potential to be affected by this practice 3.U.S. FOIA (b)(6) was in-serviced by the Administrator that all breaker panels should be locked. Director of Maintenance /designee will conduct biweekly checks on all breaker panels to	4/18/25

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	315267	A. BUILDING **01** B. WING _____	**04/17/2025**

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

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K 911	Continued From page 10 1. An observation at 10:44 AM revealed that 1 of 2 electrical breaker panels in the corridor near resident room 101 were unlocked. 2. An observation at 10:52 AM revealed that 2 of 2 electrical breaker panels behind the A wing nurses station were unlocked. 3. An observation at 11:10 AM revealed that 4 of 4 electrical breaker panels in the side corridor by the kitchen and exit were unlocked. 4. An observation at 11:43 AM revealed that 1 of 1 electrical breaker panels in the 400 corridor by the nurses station were unlocked. 5. An observation at 2:28 PM revealed 2 of 2 electrical breaker panels in the corridor by room 201 were not locked. In interviews at the times, the U.S. FOIA (b)(6) [redacted] confirmed the observation. The facility's U.S. FOIA (b)(6) [redacted]) were informed of the deficient practice at the Life Safety Code exit conference on 4/17/25 at 2:46 PM. N.J.A.C 8:39-31.2 (e) NFPA 70	K 911	make sure they are locked and preventing unauthorized access for the next 4 quarters. 4.Director of Maintenance will report the bi-weekly audits for a total of 6 per quarter to the QA committee for the next 4 quarters to ensure all breaker panels are locked.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K 918		5/8/25

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K 918	Continued From page 11 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. 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. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Repeat Deficiency Based on record review and interview on 4/17/25 in the presence of the U.S. FOIA (b)(6) it was determined the facility failed to ensure the	K 918	1. No residents were effected. Load bank test for 90 minutes was conducted by Powerhouse Generators on 5/8/25 2.All Residents have the potential to be	

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K 918	Continued From page 12 diesel power generator was exercised at 30% or greater of its nameplate rating during the monthly load tests or that a 90 minute load bank test was conducted in accordance with NFPA 110: 2010 Edition, Section 8.4, 8.4.2(2) and 8.4.2.3. This deficient practice has the potential to affect all residents and was evidenced by the following: A record review of the facilities monthly and weekly generator logs revealed there was no value recorded, or place on the log to have recorded the percent of load the generator was ran under during the monthly full load exercises for the last 12 months. Further review of the service records verified there was no record that an annual 90 minute load bank test was performed in the last 12 months, which would have been required if the monthly load values were under 30% of the nameplate rating. There was also no amperage information or total amperage under load and no voltage recorded. In an interview at the time, the U.S. FOIA (b)(6) confirmed the observation. The facility's U.S. FOIA (b)(6)) were informed of the deficient practice at the Life Safety Code exit conference on 4/17/25 at 2:46 PM. This deficient practice was cited on the previous Standard Recertification survey dated 4/11/23. N.J.A.C 8:39-31.2 (e) NFPA 99, 110	K 918	affected by this practice 3. U.S. FOIA (b)(6) was in-serviced by Administrator to run generator at 30% capacity of name plate rating during load test. Director of Maintenance will run generator at 30% capacity or more every month for 12 months in accordance with NFPA110. 4. Director of Maintenance will run monthly tests and report to the QA committee on a quarterly basis for the next 4 quarters.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101	K 923		4/18/25

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K 923	Continued From page 13 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 923		

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K 923	Continued From page 14 Based on observation and interview on 4/16/25 in the presence of the U.S. FOIA (b)(6) , it was determined the facility failed to ensure empty oxygen cylinders were segregated from full cylinders and empty cylinders were marked and freestanding cylinders were properly chained or supported in accordance with NFPA 99: 2012 Edition, Sections 11.6.5, 11.6.5.2, 11.6.5.2.3 and 11.6.2.3(11). These deficient practices had the potential to affect all residents and were evidenced by the following: Observations at 11:45 AM of the oxygen storage room revealed 2 racks with E cylinders, 3 E cylinders in cylinder carts and a freestanding E cylinder not protected from tipping. There were no signs or marking indicating full cylinders from empty cylinders. In an interview at the time, the U.S. FOIA (b) confirmed the observation. The facility's U.S. FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference on 4/17/25 at 2:46 PM. N.J.A.C 8:39-31.2 (e) NFPA 99	K 923	1. No Residents were affected by this. Director of Maintenance has secured all full and empty oxygen tanks. Director of Maintenance has designated and marked separate areas for full and empty oxygen tanks. 2.All Residents have the potential to be affected by this practice 3.U.S. FOIA (b)(6) has been in serviced by AIT to ensure all tanks are secured and areas are properly labeled. Dir of Maintenance /designee will check the oxygen room bi-weekly for the next 4 quarters to make sure all oxygen tanks are properly secured and to ensure both full and empty areas are clearly marked. 4.Director of Maintenance will report to QA committee for the next 4 quarters	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315267 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/13/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ABIGAIL HOUSE FOR NURSING & REHABILITATION	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		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0222	04/18/2025	LSC	K0271	05/21/2025	LSC	K0341	04/18/2025
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0353	05/28/2025	LSC	K0355	04/18/2025	LSC	K0911	04/18/2025
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #		Completed
LSC	K0918	05/08/2025	LSC	K0923	04/18/2025	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 4/17/2025

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO