STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315141	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABINGDON CARE & REHABILITATION CENTER	303 ROCK AVE GREEN BROOK, NJ 08812

(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 #: NJ00160122 Census: 110 Sample Size: 9 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00160122 Based on interviews and record review of other facility documentation on 12/14/22 and 12/16/22, it was determined that the facility failed to consistently perform monthly test on the facility's Wander Guard System (WGS) to ensure that the systems were operating properly to prevent residents from elopement. This deficient practice was evidenced by: During the interview with the Maintenance Director (MD) on 12/16/22 from 9:20 am to 11:20 am, the MD stated that the WGSs had to be tested for function every month to ensure that they are working properly for the safety of the residents with wanderguards.	F 921	Element #1- All doors that are secured by a wander guard system were checked to ensure functioning properly and logged appropriately Element #2 All residents who wear a wander guard have the potential to be affected by the alleged deficient practice. Element #3 A new maintenance daily rounds sheet was created by Administrator to include checking all doors that are secured by a wander guard system to ensure proper functioning. All Maintenance staff in-serviced on new form and documenting	12/21/22

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

Electronically Signed | 01/11/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315141	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 921	Continued From page 1 Review of the form "Wander Guard System", showed that the main lobby, therapy gym, elevator 1, and 2 wandering guards system were not tested for function from 3/2022 to 10/2022 which was not according to the manufactures manual. The MD was unable to explain and to provide any documented evidence as to why the WGSs were not tested for seven months, from 3/2022 to 10/2022. Review of the WGS manual showed, "Roam Alert ...User Guide ...System Testing You should perform regular tests on the system to ensure that the controllers, receivers, and tags are operating properly. Controllers Check the operation of controllers at least once a month ...Receivers Check the operation of receivers at least once a month ..." NJAC 8:39-31.4 (a)(b)	F 921	proper functioning of system. Wander Guard policy was updated to include the manufacturers recommendations of checking the system at least monthly. Element #4 Maintenance Director or designee will conduct monthly audits of the maintenance daily rounds sheet to ensure compliance. Any discrepancies will be reported to the Administrator immediately. Results of the audits will be reported to the Quality Assurance Performance Improvement Committee during the quarterly meetings.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315141	A. Building B. Wing	1/12/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ABINGDON CARE & REHABILITATION CENTER	303 ROCK AVE GREEN BROOK, NJ 08812

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 F0921 Reg. # 483.90(i) LSC	Correction Completed 12/21/2022	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
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
12/16/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO