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 07/01/2021

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 #: NJ138893, NJ138426, NJ144698 Census: 105 Sample Size: 5 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.	F 660		7/16/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/19/2021

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

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F 660	Continued From page 1 (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge	F 660		

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F 660	Continued From page 2 needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Complaint #: NJ138893 Based on record reviews and interviews, it was determined that the facility failed to implement an effective discharge plan for a resident who required home health services, physical therapy, and occupational therapy, when discharged from the facility for 1 of 3 residents (Resident #3). Resident #3 was discharged from the facility to home on EX Order 26 § 4b1 and services were not present until EX Order 26 § 4b1. Findings include: 1. Resident #3 admitted to the facility on EX Order 26 § 4b1 and had a history of EX Order 26 § 4b1 . A review of an admission Minimum Data Set (MDS) dated 07/23/2020, revealed Resident #3 had a Brief Interview of Mental Status (BIMS) score of EX out of 15, EX Order 26 § 4b1	F 660	F660 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? ELEMENT #1 Resident #3 is no longer a resident in the facility. How other residents having the potential by the same deficient practice will be identified and what corrective actions will be taken? ELEMENT #2 All residents requiring discharge planning have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur? ELEMENT #3 All residents with a planned discharge are discussed in daily Interdisciplinary Team (IDT) meetings, by 7/1/2021. The new Social Worker has been educated by Administrator and Director of	

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F 660	Continued From page 3 EX Order 26 § 4b1 A review of the baseline care plan dated 07/16/2020, indicated Resident #3 had goals to return to the community. A review of the discharge summary history from the facility physician dated EX Order 26 § 4b1 indicated Resident #3 was seen on EX Order 26 § 4b1 and Resident #3 denied any EX Order 26 § 4b1. The physician discussed discharge instructions of Resident #3 and diagnoses and treatment plan with the interdisciplinary team (IDT). Resident #3 was medically cleared for discharge to home with EX Order 26 § 4b1 for evaluations and treatment. The physician reviewed all medications before discharge and no changes were made but recommended the family not miss doses. A review of the nursing discharge summary dated 08/06/2020 indicated Resident #3 may discharge home with home health services along with EX Ord services. Resident #3 discharged with EX Order 26 § 4b1 at EX Order 26 § 4b1 A review of a social service note dated 08/07/2020, indicated the social worker (SW) spoke with family to inform them that a second EX Order 26 § 4b1 denied the referral because they were unable to provide a EX Order 26 § 4b1 during home sessions. The family member requested an alternate EX Order 26 § 4b1 service be located. The SW contacted an alternate EX Order 26 § 4b1 agency and was informed they would evaluate Resident #3 for their services. The SW informed Resident	F 660	Nursing education, on 7/1/2021 on discharge planning process and importance of documenting all communication between the resident representative, HHA, also including communication from all facility discipline team for the possible need of home health assistance and implement all the needs and the process start at admission to ensure a safe discharge. The Social Worker will use the Discharge Planning Monitoring/Audit Tool, developed by the Administrator, to ensure that elements of a safe discharge are consistently met. The Discharge Planning Monitoring/Audit Tool will be used for all residents to be discharged in the next 6 months, tool is used daily as of (date used – should be after survey) and ongoing. The Administrator/Designee will audit the Discharge Planning Monitoring /Audit Tool daily x 2 weeks, then weekly x 6 weeks, then monthly x 4 months to ensure compliance. How the corrective actions will be monitored to ensure the deficient practice will not reoccur and what quality assurance program will be put into place? ELEMENT #4 The results of the Audit will be presented during the monthly Quality Assurance Performance Improvement meetings to monitor compliance.	

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F 660	Continued From page 4 #3's family. A phone interview was conducted on 06/30/2021 at 11:30 AM with the EX Order 26 § 4b1 agency. The EX Order 26 § 4b1 agency indicated that a telephone interview was conducted on 06/30/2020 at 11:30 AM with the clinical director of the EX Order 26 § 4b1 service. A referral was received from the facility on 08/09/2020 and the EX Order 26 § 4b1 agency attempted to contact the family member on 08/09/2020 and received a return call on 08/10/2020 from the family member, with agreement for an appointment on 08/11/2020. She stated Resident #3 was evaluated by a registered nurse on EX Order 26 § 4b1 in the home and the EX Order 26 § 4b1 services were initiated on EX Order 26 § 4b1 . An interview was conducted with Resident #3's family member on 06/28/2021 at 3:33 PM and it was indicated the facility did not have the EX Order 26 service in place when the resident discharged home. It was verified the EX Order 26 § 4b1 services were started on 08/11/2020. An attempt to interview the former EX Order 26 § 4b1 was made on 06/30/2021 at 10:30 AM but was unsuccessful. During an interview with the Administrator on 06/30/2021 at 1:34 PM, he indicated that he had completed a timeline for Resident #3's discharge that revealed the following the SW reached out to the EX Order 26 § 4b1 agency via email to refer for Resident #3 on 08/06/2020 at 12:53 PM. The EX Order 26 § 4b1 agency confirmed that Resident #3 could not be a resident with this agency because of Resident #3's EX Order 26 § 4b behaviors to staff in the past. A second referral was made on 08/06/2020	F 660	Quarterly Reports will be presented during the QAPI meetings to identify trends and recommendations	

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F 660	Continued From page 5 at 3:59 PM to another Ex.Order 26.4(b)(1) agency who also confirmed that Resident #3 was not accepted as resident. During a follow up interview with the Administrator on 07/01/2021 at 11:00 AM, he stated he was not the Administrator during this incident, however, the former social worker was responsible for completing the discharge for Resident #3. The Administrator indicated the EX Order 26 § 4b1 services should have been in place prior to discharge as ordered by the physician. The Administrator also indicated that the referral should had been made before the day of discharge and a follow up should have been done to assure Resident #3 had EX Order 26 § 4b1 services in place. New Jersey Administrative Code § 8:39-39.4(f) New Jersey Administrative Code § 8:39-5.4(b)	F 660		

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
315141 (Y1)	A. Building B. Wing (Y2)	7/19/2021 (Y3)

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 F0660 Reg. # 483.21(c)(1)(i)-(ix) LSC	Correction Completed 07/16/2021	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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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	
7/1/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO