STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315068	A. Building B. Wing	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dwellside Care and Rehab	3025 Chapel Avenue West Cherry Hill, NJ 08002

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48618 COMPLAINT #: NJ00167155 Based on interviews, medical record review, and review of other pertinent facility documents on 1/26/24 and 1/30/24, it was determined that the facility failed to initiate a comprehensive person center care plan for a resident with a vaginal infection. The facility also failed to follow its undated policy titled Nursing Documentation. This deficient practice was identified for 1 of 2 residents (Resident #4) reviewed for comprehesive Care Plan (CP) and was evidenced by the following: Review of the Medical Record was as follows: According to the Face Sheet, Resident #4 was admitted to the facility with diagnoses that included but were not limited to: Multiple Sclerosis (a condition that happens when the immune system attacks the brain and spinal cord), neuromuscular dysfunction of bladder (lacking bladder control), and Vaginitis, vulvitis, and vulvovaginitis (vaginal infections). The surveyor reviewed the progress notes (PN) for Resident #4 which revealed: -A Physician PN, dated 08/22/23, at 3:22 P.M., Resident #4 was receiving treatment for: Anogenital candidiasis of female (a fungal infection caused by a yeast called Candida) -A Physician PN, dated 09/12/23 at 9:10 P.M., Resident #4 was receiving treatment for: Candida Vaginitis (an infection caused by a yeast) The surveyor reviewed the Order Summary Report for Resident #4 which revealed the following active Physician Orders (PO): -Nystatin External Cream, related to Acute Candidiasis of vulva and vagina, Order date: 08/22/23 Review of the Care Plan (CP) for Resident #4's failed to reveal a focus and interventions that address the resident's vaginal infections. On 01/30/24 at 12:30 P.M., the surveyor interviewed Licensed Practical Nurse (LPN) #2, who said that the Unit Manager is responsible for updating and initiating CPs. LPN #2 further stated that it is important that the CP be kept up to date so that the needs of the resident could be met. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/30/24 at 12:40 P.M., the surveyor interviewed the Unit Manager/LPN (UM/LPN) #2, who said that the unit/nurse manager, or the Director of Nursing (DON), are responsible for updating CPs. He further explained that the, CPs were usually updated during care conferences, or if new issues develop. UM/LPN #2 added that CPs were important because it was the plan of care for the resident. The UM/LPN #2 further stated that the CP should be updated to reflect the infection as soon as a treatment is ordered. On 01/30/24 at 01:30 P.M., the surveyor interviewed the DON who said that the CP was the individualized plan of care for each resident and that, All changes in a resident's clinical and/or functional status are to be reflected there. The DON further explained that any member of the interdisciplinary team could update the CP. The surveyor asked the DON if a resident develops an infection that requires treatment, would that be reflected on the CP? The DON stated, Yes, anything new should be reflected on the CP. The DON reviewed Resident #4s CP in the presence of the surveyor. The surveyor asked if Resident #4's CP addressed vaginal infections, at which time the DON requested for an opportunity to search the CP's history as there may not be a current diagnosis. The DON did not provide the surveyor with any additional documentation regarding Resident #4's CP. A review of the facility's undated Policy/Procedure Nursing Documentation policy revealed that documentation was to be accurately maintained at all times. NJAC: 8:39-11.1 NJAC: 8:39-11.2(i)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48618 COMPLAINT #: NJ00170403 Based on interviews, medical record review, and review of other pertinent facility documents on 1/26/24 and 1/30/24, it was determined that the facility staff failed to consistently document in the Documentation Survey Report (DSR) the Activities of Daily Living (ADL) status and care provided to the resident according to facility policy and protocol for 2 of 2 residents (Resident #4 and Resident #5) reviewed for documentation. This deficient practice was evidenced by the following: 1.) According to the Admission Record (AR), Resident #4 was admitted to the facility with diagnoses that included but were not limited to: Multiple Sclerosis (a condition that happens when the immune system attacks the brain and spinal cord), muscle weakness, and epileptic seizures. The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/04/23, indicated that Resident #4 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that the resident's cognition was intact. The MDS also indicated that the resident needed assistance with ADLs including bed mobility (turning and positioning), toilet transfer, dressing, and transfers. A review of the Resident #4's Care Plan (CP) noted that the resident required extensive assistance with bed mobility, dressing, toileting, and transfers. Review of Resident #4's DSR (ADL Record) and the progress notes (PN) for 1/1/24 thru 1/25/24, lack any documentation to indicate that the care for bed mobility (turn and positioning), toilet use, dressing, and transfers was provided and/or the resident refused care on the following dates and shifts: 7:00 am-3:00 pm shift on 1/5/24, 1/6/24, 1/20/24, 1/23/24, and 1/24/24. 3:00 pm-11:00 pm shift on 1/1/24, 1/2/24, 1/7/24, 1/8/24, 1/10/24, 1/12/24, 1/24/24, and 1/25/24. 11:00 pm-7:00 am shift on 1/4/24, 1/15/24, 1/20/24, and 1/24/24. 2.) According to the AR, Resident #5 was admitted to the facility with diagnoses that included but were not limited to: Multiple Sclerosis (a condition that happens when the immune system attacks the brain and spinal cord), muscle weakness, and restless leg syndrome. The Quarterly MDS, dated [DATE], revealed that Resident #5 had a BIMS of 14 out of 15 which indicated that the resident's cognition was intact. The MDS also indicated that the resident needed substantial assistance with toileting, dressing, and bed mobility (turning and positioning), and transfers. A review of the Resident #5's CP noted that the resident required extensive assistance with bed mobility, dressing, toileting, and transfers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #5's DSR and the PN for 1/1/24 thru 1/12/24, lacked any documentation to indicate that the care for bed mobility (turn and positioning), toilet use, and dressing was provided and/or the resident refused care on the following dates and shifts; -7:00 am-3:00 pm shift on 1/6/24 and 1/12/24. -3:00 pm-11:00 pm shift on 1/2/24, 1/8/24 thru 1/10/24, and 1/12/24. -11:00 pm-7:00 am shift on 1/4/24. Review of Resident #5's DSR and the PN for 1/1/24 thru 1/12/24, lack any documentation to indicate that the care for transferring was provided and/or that the resident refused care on the following dates and shifts; -7:00 am-3:00 pm shift on 1/6/24 and 1/12/24. -3:00 pm-11:00 pm shift on 1/2/24, and 1/8/24 thru 1/12/24. -11:00 pm-7:00 am shift on 1/4/24. On 01/26/24 at 10:49 A.M., the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) #1 who said it was important to document ADL care so that the care team was aware that care was provided to the resident and at what level of assistance the resident required. UM/LPN #1 explained that Certified Nurse Aides (CNA) were responsible for providing ADL care and documenting the care provided in the electronic system. UM/LPN #1 said that it is expected that all care be documented at least twice a shift and that there should be no missing documentation on the ADL reports [DSR]. On 1/30/24 at 11:40 A.M., the surveyor interviewed CNA #2 who said that CNAs were responsible for documenting ADLs. She further stated that all documentation is entered into the electronic system, and that it is to be done at least twice a shift. CNA #2 said, If there are blanks, it means that the CNA did not document the care that was done. CNA #2 further stated that, There should be no blanks and that documentation is important to show all of the care that the residents received. On 01/30/24 at 11:50 A.M., the surveyor interviewed LPN #1, who said that CNAs were responsible for completing all ADL care. LPN #1 also said that the CNAs documented all care in the electronic system. LPN #1 further said that there should be no blanks in the system, Blanks mean that the task wasn't completed. On 01/30/24 at 01:30 P.M., the surveyor interviewed the Director of Nursing (DON) who stated that the CNAs were responsible for providing ADL care and documenting in the electronic system throughout the shift. He further explained that it was the responsibility of the nurse supervisor to ensure that the CNAs completed and documented the completion of the tasks. The DON said, There should not be any [missing documentation] blanks. That it could mean that it wasn't done, or it could also mean that the CNA forgot. There is no way for me to know which one, but the expectation is that all care is documented and there should be no blanks. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Activities of Daily Living (ADLs) policy, revised October 2023, reflected A resident who is unable to carry out ADLs will receive the necessary services . The policy further noted that, All ADLs will be documented at a minimum daily in resident record. NJAC 8:39-35.2(d)(9)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 48618 COMPLAINT #: NJ00166293 Based on observation, interview, record review, and other facility documentation on 1/26/24 and 1/30/24, it was determined that the facility failed to submit a specimen to the laboratory in a timely manner. This deficient practice was identified for 1 of 1 resident (Resident #4)reviewed for laboratory services and was evidenced by the following: The surveyor reviewed the medical record for Resident #4. According to the Admission Record, Resident #4 was admitted to the facility with diagnoses that included but were not limited to Multiple Sclerosis (is a condition that happens when the immune system attacks the brain and spinal cord), muscle weakness, and epileptic seizures. The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/04/23, indicated that Resident #4 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that the resident's cognition was intact. The surveyor reviewed Resident #4's Order Summary Report (OSR) for the active orders as of 08/01/23, which reflected that a Stool for c-diff was ordered on 08/01/23. The surveyor reviewed the Resident #4's Progress Notes (PN) for August 2023 which revealed that on 08/02/23 at 6:09 P.M. a Stool specimen was collected and placed in fridge specimen fridge [at 6:00 A.M.], by the Unit Manager/Licensed Practical Nurse (UM/LPN) #1. The PN did not reveal any further documentation regarding when the lab picked up Resident #4's stool specimen. The surveyor reviewed a Lab Result Report that was provided by the facility which reflected the following: -Collection Date: 08/08/23 12:00 P.M. -Received Date: 08/08/23 12:51 P.M. -Reported Date: 08/08/23 1:25 P.M. On 01/26/24 at 2:50 P.M., the surveyor interviewed the UM/LPN #1, who stated that after a doctor puts in an order for a stool sample it was the responsibility of the nurse to obtain the sample as soon as possible. He further explained that, Once the sample is obtained, it is placed in the fridge for the next pick-up day. Pick-up days are Tuesdays and Fridays. When the surveyor asked UM/LPN #1 why Resident #4's specimen was not received by the lab until 08/08/23? UM/LPN #1 stated that he could not recall when the specimen was picked up but that it should have been on the next scheduled day. On 01/26/24 at 3:00 P.M., the surveyor interviewed the Director of Nursing (DON) who stated that, Once collected, the specimens are [would] placed in the designated fridge and staff contact the lab to schedule pick-up on the next scheduled day. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up telephone interview, on 02/08/24 at 3:24 P.M., the DON said that the facility's scheduled lab pick-up days were Tuesdays & Fridays. The surveyor asked why Resident #4s 08/02/23 stool specimen was not picked up until 08/08/23. The DON said that ideally it should have been picked up on 08/04/23. No additional information was provided to the surveyor. During a telephone interview with the surveyor, on 02/09/2024 at 12:21 P.M., the physician said that the facility had a contract with a laboratory to pick up on Tuesdays and Fridays. The physician further stated, Unless a lab was ordered as 'stat', the expectation was that it would be picked on the next Tuesday or Friday, whichever was first. The physician said that this included stool specimens. The physician said although she recalled working with Resident #4, she could not recall the details of the event. The surveyor asked if it was reasonable for a stool specimen that was collected on 08/02/23 take six days to get to the lab [08/08/23] and the physician said, I am unsure as to why it took six days, but it should have been sooner. The physician further stated, I would have expected that the specimen should have been picked up on the next scheduled day [08/04/23]. Review of the facility's Laboratory Services and Reporting policy, revised October 2023, indicated, The facility must provide or obtain services when ordered by a physician . The policy also indicated that the laboratory services are to meet the needs of its residents and that, .The facility is responsible for the appropriateness of the laboratory services . N.J.A.C. 8:39-11.2(b)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48618 Complaint #: NJ00165770 Based on observation, interview, record review, and review of other pertinent facility documentation on 01/26/24 and 01/30/24, it was determined that the facility failed to provide shower care to a resident that was dependent on staff for activities of daily living (ADLs). This deficient practice was identified for 1 of 2 residents (Resident #4) reviewed for showers, and was evidenced by the following: The surveyor reviewed the medical record for Resident #4. According to the Admission Record, Resident #4 was admitted to the facility with diagnoses that included but were not limited to Multiple Sclerosis (is a condition that happens when the immune system attacks the brain and spinal cord), muscle weakness, and epileptic seizures. The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 12/04/23 revealed that Resident #4 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that the resident's cognition was intact. The MDS also indicated that the resident required substantial assistance with showering. Review of Resident #4's Care Plan (CP) revealed a Focus, initiated on 03/18/22, that Resident #4 had an ADL self-care performance deficit related to Multiple Sclerosis and deconditioning. The CP indicated that the resident required extensive assistance with bathing. On 01/26/24 at 10:38 A.M., the surveyor observed Resident #4 sitting up in bed, wearing a hospital gown. The resident's hair was damp, and the gown and bedding were clean. Resident #4 said that he/she had just returned to the room after receiving a shower. Resident further stated that, I'm receiving my showers as scheduled now, but I was not getting them back in July [2023]. The surveyor reviewed the resident's Documentation Survey Report v2 (DSR) for July 2023 and noted that there was no documentation noted for Bathing on July 12, 2023, on the 7:00 A.M. to 3:00 P.M. shift. Review of Resident #4's Progress Notes for July 2023 revealed no documentation regarding showers/baths on July 12, 2023. On 01/26/24 at 10:49 A.M., the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) #1 who stated it was important to document ADL care so that the care team was aware that care was provided to the resident and at what level of assistance the resident required. UM/LPN #1 explained that Certified Nurse Aides (CNA) were responsible for providing ADL care and documenting the care provided in the electronic system. UM/LPN #1 stated that showers were scheduled twice a week and were usually assigned based on room and bed numbers. He added that accommodations were also made based on residents' preferences. UM/LPN #1 further stated that it is expected that all care be documented at least twice a shift and that there should be no missing documentation on the ADL reports [DSR]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/30/24 at 11:50 A.M., the surveyor interviewed LPN #1, who said that CNAs were responsible for completing all ADL care. LPN #1 added that the CNAs documented all care in the electronic system. She stated that it was important to document ADL care because it reflected that the care was provided and at what level of assistance the resident received. LPN #1 further stated that there should be no blanks in the system and that, Blanks mean that the task wasn't completed. On 01/30/24 at 01:30 P.M., the surveyor interviewed the Director of Nursing (DON) who stated that ADL documentation reflected how much a resident can participate in their own care. He said that the CNAs were responsible for providing ADL care and documenting in the electronic system throughout the shift. He further explained that it was the responsibility of the nurse supervisor to ensure that the CNAs completed and documented the completion of the tasks. The DON said, There should not be any [missing documentation] blanks. That it could mean that it wasn't done, or it could also mean that the CNA forgot. There is no way for me to know which one, but the expectation is that all care is documented and there should be no blanks. During a telephone interview on 02/06/24 at 03:25 P.M., CNA #1 said that CNAs were responsible for ADL care and that everything was documented in the electronic system. She further stated that showers/baths were provided twice weekly. She explained that if a resident were to refuse, the CNA was to try again later, in addition to notifying the nurse and documenting. CNA #1 said, I try to document at least twice a shift, around lunch time and before the end of the day. There are times, rarely, when I forget but I try to do it right then and there because if it wasn't documented it wasn't done. She further explained, [Resident #4] rarely ever refuses if I'm there. I must have forgotten. Review of the facility policy, Activities of Daily Living, with a last revised date of October 2023, indicated that All ADLs will be documented at a minimum daily in resident record. NJAC 8:39-27.1(c), 27.2(i)