STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315104	A. BUILDING _____ B. WING _____	C 11/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNELL HALL CARE & REHABILITATION CENTER	**234 CHESTNUT STREET UNION, NJ 07083**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D 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 .C #NJ 140116 Census: 96 Sample Size: 4	F 000		
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: C #: NJ 140116 Based on observation, interviews, record review as well as review of other pertinent documents on 11/4/20, it was determined that the facility failed to ensure residents were provided with quarterly statements of their Personal Needs Account (PNA) for 2 of 4 residents (Residents #1 and #2) reviewed for PNA records. This deficient practice is evidenced by the following: 1. According to "ADMISSION RECORD (AR)" Resident #1 was admitted to the facility on [redacted].	F 568	1. Resident #1 and #2 were immediately provided with a quarterly statement of their Personal Needs Accounts (PNA)and current balance. Both residents #1 and #2 quarterly statement of their Personal Needs Accounts were reviewed and both residents signed off that it was received and recorded. 2. All Residents have the potential to be affected by this deficient practice. 3. Business Office Manager (BOM),Social Service Worker or designee	11/30/20

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/12/2020

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315104	A. BUILDING _____ B. WING _____	C 11/04/2020

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F 568	Continued From page 1 The "Order Summary Report (OSR)" dated 11/5/20 showed the diagnosis which included but was not limited to: NJ Exec. Order 26:4.b.1. The Minimum Data Set (MDS), an assessment tool, dated 10/21/20 showed that the Resident had NJ Exec. Order 26:4.b.1. The surveyor conducted an interview with Resident #1 on 11/4/20 at 10:00 am. The Resident stated that he/she did receive the quarterly PNA statement. The Resident went on to state that the last PNA statement received was May or June 2020. Resident #1 revealed that he/she remembered requesting the quarterly PNA statement from the Business Office. However, none was provided from the last quarter which was September 2020. 2. According to the AR Resident #2 was initially admitted to the facility on NJ Exec. Order 26:4. The OSR dated 11/5/20 showed the diagnosis which included but was not limited to: NJ Exec. Order 26:4.b.1 The MDS dated 10/10/20 showed that the Resident had NJ Exec. Order 26:4.b.1. The surveyor conducted an interview with Resident #2 on 11/4/20 at 9:40 am. Resident #2 stated that he/she would not know the balance left on his/her PNA because the facility did not provide the quarterly statement of his/her PNA for the month of September 2020. The surveyor conducted an interview with the Regional Business Manager (RBM) on 11/4/20 at	F 568	were re-educated on Accounting and Records of Personal Funds as it relates to providing all residents with a copy of their quarterly statements of their Personal Needs Account (PNA) for review for PNA records. 4. Business Office Manager (BOM), Social Service Worker or designee will audit weekly/monthly Accounting and Records of Personal Funds (PNA) and current balance/quarterly statement of their Personal Needs sent of out to all residents for timely recorded keeping and evidence that it was received and reviewed by resident an or responsible party monthly x 4 quarters. The results of these audits will be brought to Administrator and reviewed. All audits results will be reviewed and trends identified will be used in the quarterly assurance performance improvement plan (QAPI) for review and recommendations.	

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	315104	A. BUILDING _____ B. WING _____	C 11/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNELL HALL CARE & REHABILITATION CENTER	**234 CHESTNUT STREET UNION, NJ 07083**

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F 568	Continued From page 2	F 568		

10:26 am, she stated that residents received their quarterly PNA statement from the Business Office staff. She stated that for residents who were cognitively intact a copy would be provided with the resident signature after it was reviewed with the resident. She stated that she would check her file to see if Residents #1 and #2 received their quarterly PNA statements for September 2020 and would inform the Administrator of her findings.

The surveyor conducted an interview with the Administrator on 11/4/20 at 12:21 pm. He stated that Residents #1 and #2 did not get their quarterly PNA statements for September 2020. He explained that their was a miscommunication between the RBM and the Social Worker (SW) on who would give the quarterly statements to the residents. He further explained that moving forward it would be the RBM's and the SW's responsibility to provide the residents with their quarterly PNA bank statements.

The surveyor attempted to conduct a telephone interview with the SW on 11/5/20 at 12:26 pm. However, the SW was not available.

The Job Description titled "BUSINESS OFFICE MANAGER" was revised on 9/06 showed "...RESPONSIBILITIES/ACCOUNTABILITIES:.... 2 Manages resident trust funds and maintains confidential files;...8. Ensures that residents and families receive the highest quality of service in a caring and compassionate atmosphere which recognizes the individual's needs and rights; 9. Performs other duties as requested..."

The Job Description titled "SOCIAL WORKER" was revised on 9/06 showed

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	315104	A. BUILDING _____ B. WING _____	C 11/04/2020

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F 568	Continued From page 3 "RESPONSIBILITIES/ACCOUNTABILITIES...11. functions in a manner that adheres to all policies/procedures of the facility...15 Ensures that residents and families receive the highest quality of service in a caring and compassionate atmosphere which recognizes the individual's needs and rights; 9. Performs other duties as requested..." The undated policy titled "RESIDENT PERSONAL NEEDS FUNDS" showed "...PROCEDURE...7. Quarterly Statements...c. For all alert and oriented residents, a copy will be given to the social worker to be reviewed with the resident..." NJAC 8:39-4.1 (a)9	F 568		

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)
315104	A. Building B. Wing	12/1/2020

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNELL HALL CARE & REHABILITATION CENTER	234 CHESTNUT STREET UNION, NJ 07083

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 F0568 Reg. # 483.10(f)(10)(iii) LSC	Correction Completed 11/30/2020	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	
11/4/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO