STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315507	A. BUILDING _____ B. WING _____	C 06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNERT SUBACUTE REHABILITATION CENTER, LLC	**680 BROADWAY SUITE 301 PATERSON, NJ 07514**

(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 A Complaint Survey was conducted on behalf of the New Jersey Department of Health. Complaint #: NJ00154217, NJ00157394, NJ00158696, NJ00159962, NJ00161868, NJ00163247, and NJ00164243. Survey Dates: 06/14/23 through 06/16/23 Survey Census: 50 Sample Size: 15 THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		

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

Electronically Signed | 07/11/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16008	A. BUILDING: _____ B. WING _____	C 06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNERT SUBACUTE REHABILITATION CENT	680 BROADWAY SUITE 301 PATERSON, NJ 07514

(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 000	Initial Comments Complaint #: NJ00154217, NJ00157394, NJ00158696, NJ00159962, NJ00161868, NJ00163247, and NJ00164243. Survey Dates: 06/14/23 through 06/16/23 Survey Census: 50 Sample Size: 15 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 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 6 of 42 day shifts and 1 of 28 evening shifts as	S 560	Concern. S560 Mandatory Access to care. How the corrective action will be	7/24/23

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

Electronically Signed | 07/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16008	A. BUILDING: _____ B. WING _____	C 06/16/2023

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BARNERT SUBACUTE REHABILITATION CENT	680 BROADWAY SUITE 301 PATERSON, NJ 07514

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S 560	Continued From page 1 follows: This deficient practice had the potential to affect all residents. Findings include: 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 as N.J.S.A. 30:13-18 (the Act), which 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 of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide 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. As per the "Nurse Staffing Report" completed by the facility for the 4 weeks of staffing from 04/30/2023 to 05/13/2023 and 2 weeks of staffing from 05/28/2023 to 06/10/2023, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift and one direct care staff member to every 10 residents for the evening shift as documented below: 1. For the 4 weeks of complaint staffing from	S 560	accomplished for any resident affected by deficient practice. 1. All efforts to hire facility Certified Nursing Aide(s) C.N.A will continue until there is adequate staff to serve all residents. Until the time, facility will utilize staffing agencies to fill any open spots in the schedule .Contracts with additional staffing agencies will be secured to supplement facility staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to become more competitive in the marketplace and surrounding area. In addition, daily and weekly meetings with the staffing coordinator. No resident was affected with this deficient practice. How we identified other residents/areas that could potentially be affected. 2. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents(current and future). Measures to ensure were/will be put into place to assist this area of concern. 3. Contracts with additional staffing agencies will be secured to supplement facility staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to become more competitive in the marketplace and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16008	A. BUILDING: _____ B. WING _____	C 06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNERT SUBACUTE REHABILITATION CENT	680 BROADWAY SUITE 301 PATERSON, NJ 07514

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S 560	Continued From page 2 04/30/2023 to 05/13/2023, the facility was deficient in CNA staffing for residents on 5 of 28 day shifts and deficient in CNAs to total staff on 1 of 28 evening shifts as follows: -05/09/23 had 5 CNAs for 45 residents on the day shift, required 6 CNAs. -05/21/23 had 5 CNAs for 56 residents on the day shift, required 7 CNAs. -05/24/23 had 6 CNAs for 58 residents on the day shift, required 7 CNAs. -05/25/23 had 6 CNAs for 57 residents on the day shift, required 7 CNAs. -05/25/23 had 6 CNAs to 14 total staff on the evening shift, required 7 CNAs. -05/27/23 had 5 CNAs for 57 residents on the day shift, required 7 CNAs. For the 2 weeks of staffing from 05/28/2023 to 06/10/2023, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: -05/28/23 had 6 CNAs for 55 residents on the day shift, required 7 CNAs.	S 560	surrounding area. In addition, daily and weekly meetings with the staffing coordinator. The Administrator or designee will review staffing schedules weekly for 4 weeks and monthly for 3 months to ensure adequate staffing for all shifts. How the concern will be monitored and title of person responsible for monitoring. 4. The results of these reviews will be submitted to the (Quarterly Assurance Performance Improvement (QAPI) committee for review. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting/review. Dates when concern will be completed. 07/24/23.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315507	A. BUILDING _____ B. WING _____	R-C 07/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 000}	INITIAL COMMENTS	{F 000}		

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

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STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
16008 Y1	A. Building B. Wing Y2	7/24/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNERT SUBACUTE REHABILITATION CENTER, LLC	680 BROADWAY SUITE 301 PATERSON, NJ 07514

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 07/24/2023	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 6/16/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			