

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

PRINTED: 09/25/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315201</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>08/08/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAMBRIDGE REHABILITATION AND HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>255 EAST MAIN ST</b> <b>MOORESTOWN, NJ 08057</b>		
(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 #: NJ00172104, NJ00173497, NJ00174369, NJ00174774  Census: 150  Sample Size: 6  The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/30/2024

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.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>030305</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/08/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAMBRIDGE REHABILITATION AND HEALTHCARE CI</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>255 EAST MAIN ST</b> <b>MOORESTOWN, NJ 08057</b>		
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S 000	Initial Comments  The facility was not in compliance with the standards in the New Jersey Administrative code, 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 14 of 14 day shifts. The deficient practice was evidenced by the following:  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	S 560	What corrective action will be accomplished for those residents affected by the deficient practice?  The facility leadership team has met on an ongoing basis and continue to identify staffing challenges and areas of improvement for certified staffing needs.  No residents were affected by not meeting the State of NJ minimum staffing requirements as determined by routine monitoring and review on those dates that no significant changes were noted.  How will the facility identify other residents having the potential to be affected by the	8/30/24

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S 560	<p>Continued From page 1</p> <p>effective on 02/01/2021:</p> <p>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.</p> <p>The surveyor requested staffing for the weeks of 07/21/2024 to 08/03/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:</p> <p>-07/21/24 had 15 CNAs for 156 residents on the day shift, required at least 19 CNAs. -07/22/24 had 18 CNAs for 155 residents on the day shift, required at least 19 CNAs. -07/23/24 had 17 CNAs for 154 residents on the day shift, required at least 19 CNAs. -07/24/24 had 15 CNAs for 154 residents on the day shift, required at least 19 CNAs. -07/25/24 had 17 CNAs for 153 residents on the day shift, required at least 19 CNAs. -07/26/24 had 18 CNAs for 151 residents on the day shift, required at least 19 CNAs. -07/27/24 had 16 CNAs for 149 residents on the day shift, required at least 19 CNAs.  -07/28/24 had 14 CNAs for 149 residents on the day shift, required at least 19 CNAs. -07/29/24 had 12 CNAs for 149 residents on the day shift, required at least 19 CNAs.</p>	S 560	<p>same deficient practice?</p> <p>Any resident residing in the center has the potential to be affected.</p> <p>What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>The facility has evaluated rates and established fair market rates for certified nursing assistants.</p> <p>The facility has implemented an incentive program including sign-on bonuses for new hires, and referral bonuses for employees referring staff.</p> <p>The facility will conduct ongoing job fairs, internally, virtually and externally with immediate interviews and contingency offers.</p> <p>The facility implemented an expedited and robust onboarding process for new hires.</p> <p>The facility will continue to partner with NEHA Academy for clinical rotations and Nursing Assistant schooling.</p> <p>The facility will offer sponsored free attendance at the NEHA CNA training program offered continuously throughout the year</p> <p>The facility will use a recruiter to assist with attracting new hires both licensed and non-licensed.</p>	

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S 560	Continued From page 2  -07/30/24 had 15 CNAs for 149 residents on the day shift, required at least 19 CNAs. -07/31/24 had 12 CNAs for 148 residents on the day shift, required at least 18 CNAs -08/01/24 had 16 CNAs for 148 residents on the day shift, required at least 18 CNAs. -08/02/24 had 16.5 CNAs for 148 residents on the day shift, required at least 18 CNAs. -08/03/24 had 14 CNAs for 148 residents on the day shift, required at least 18 CNAs.	S 560	The facility will monitor retention and turnover rates.  The center will implement employee programs to enhance company culture and retention.  The facility will continue to monitor attendance, callouts and staffing patterns and needs.  The facility will continue to utilize social media, employment sites and recruitment efforts to hire new staff members.  How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?  The DON and/or Designee will meet with the staffing coordinator daily to review facility census, call outs if any and staffing needs.  The DON and/or Designee will monitor call outs and staffing ratios weekly until the requirement is met and compliance is maintained.  The results of the audits will be forwarded to the facility administrator and QAA Committee daily x1 week, weekly x3 weeks and monthly x3 months for further review and recommendations as needed.	

## STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 030305	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 9/10/2024
NAME OF FACILITY CAMBRIDGE REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 255 EAST MAIN ST MOORESTOWN, NJ 08057	

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/30/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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 8/8/2024		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			