STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315229	A. BUILDING ______ B. WING ______	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX CENTER FOR REHABILITATION AND PEDIATRICS	**1433 RINGWOOD AVE HASKELL, NJ 07420**

(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 # NJ00166871 NJ00167992 NJ00168034 Survey Census: 198 Sample Size: 4 THE FACILITY IS NOT 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		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		11/20/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: — (X6) DATE: 11/03/2023

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.

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F 609	Continued From page 1 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, as well as a review of pertinent facility documents on 10/4/23, 10/4/23, 10/6/23, and 10/11/23, it was determined that the facility staff failed to report an Ex Order 26. 4B1 to the New Jersey Department of Health (NJDOH) and follow their policy titled Abuse Prevention for 1 of 3 residents (Resident #4) reviewed for incident and accident. This deficient practice is evidenced by the following: On 10/4/23 at 9:16 a.m., during the entrance conference with the Administrator and the Director of Nursing (DON), the facility provided the Resident's Ex Order 26. 4B1 which included Resident #4. During an interview with the surveyor on 10/4/23 at 12:01 p.m. Resident # 4 made an Ex Order 26. 4B1. Resident #4 reported that "Ex Order 26. 4B1" Resident #4 stated that the CNA called her/him "Ex Order 26. 4B1," "Ex Order 26. 4B1," "Ex Order 26. 4B1," and that she/he was a "Ex Order 26. 4B1." Resident #4 stated that she felt like a less person after hearing the CNA's comments. According to Resident #4, he/she reported Ex Order 26. 4B1 to the nurse (unable to	F 609	IMMEDIATE ACTION On 10/4/2023, C.N.A. #1 was suspended pending investigation. DON reported the allegation from resident #4 to NJ Department of Health and Ombudsman Office. The investigation started immediately. Assistant Director of Nursing was re-educated on Abuse Prevention Policy and reporting on 10/4/2023 by Director of Nursing. IDENTIFY OTHERS: On 10/4/2023, All residents that has the potential to be affected by the same deficient practice were reviewed on 10/4/2023 by social worker/designee with no additional findings. INSERVICES: The facility's Interdisciplinary Team reviewed Abuse Prevention Policy with revisions to include immediate notification to Director of Nursing and or Administrator of all allegations of abuse, mistreatment, and neglect on 10/6/2023. On 10/6/2023, in-service on Abuse Prevention to all staff including agencies was initiated and completed on 10/08/2023. QAPI:	

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F 609	Continued From page 2 recall the name of the nurse), and to the Assistant Director of Nursing (ADON #1) was also aware. According to the Admission Record (AR), Resident #4 was admitted to the facility on Ex Order 26. 4B1, with diagnoses that included but were not limited to Ex Order 26. 4B1 The Minimum Data Set (MDS), an assessment tool dated NJ Exec. Order 26:4.b, Resident #4 had a Brief Interview for Mental Status (BIMS) score of Ex Ord/15, which indicated the resident was Ex Order 26. 4B1. The MDS also indicated Resident #4's Activities of Daily Living (ADLs) required NJ Exec. Order 26:4.b.1 herself/himself. A review of Resident #4's Care Plan (CP) initiated on NJ Exec. Order 26:4.b, indicated that Resident #4 had Ex Order 26. 4B1 . Further review of Resident's CP initiated on NJ Exec. Order 26:4 indicated that Resident #4 had NJ Exec. Order 26:4.b.1 as evidenced by NJ Exec. Order 26:4.b.1 at staff. During an interview with the surveyor on 10/4/23 at 12:15 p.m., ADON #1 stated that on 8/31/23, Resident #4 reported that CNA #1 would not transfer Resident #4 out of bed and told Resident #4 "Ex Order 26. 4B1," "Ex Order 26. 4B1	F 609	Director of Nursing/designee will perform monthly audits on Abuse Prevention & Reporting for the first 3 months then quarterly thereafter. Any negative findings will have immediate corrective actions taken by Director of Nursing and reported to the Administrator. All findings of the audits will be presented during the QAPI meetings held quarterly by the Director of Nursing /designee and will be ongoing until 100 percent compliant attained.	

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F 609	Continued From page 3	F 609		

Ex Order 26. 4B1," and "Ex Order 26. 4B1" The ADON further stated that the CNA was educated and was assigned to other residents to provide care. She further stated that the DON was made aware, however, she was not sure if the Ex Order 26. 4B1 was reported to the NJDOH. The ADON explained that any allegation of any form of Ex Order 26. 4B1 should be investigated thoroughly and reported to the NJDOH.

There was no indication in the MR that Resident #4 Ex Order 26. 4B1 was thoroughly investigated and reported to the NJDOH which was not according to the facility policy.

The surveyor conducted the interview with the Administrator and Director of Nursing (DON) on 10/4/23. 10/5/23, and 10/6/23. They stated that they were not aware the Ex Order 26. 4B1 involving Resident #4 and CNA #1 occurred NJ Exec. Order 26:4.b until 10/4/23. The Administrator stated that the aforementioned incident should have been investigated and reported to the NJDOH.

A review of the facility's policy titled "Abuse Prevention," dated 10/4/2023 indicated " ... IDENTIFICATION: The facility will investigate all incidents involving actual or alleged abuse, complaints/grievances...INVESTIGATION: The facility will investigate all incidents involving actual or alleged abuse, complaints/grievances...PROTECTION: the facility will protect all residents during any abuse investigation by removing staff from direct care and/or removing from schedule pending conclusion. REPORTING: In response to allegations of abuse...the facility must ensure that: all allegations of abuse must be immediately reported to the Director of Nursing and or

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F 609	Continued From page 4 Administrator and no later than 2 hours to other officials (including to the State Survey Agency) after the allegation is made, if the event that caused the allegation involve abuse or result in a serious bodily injury..." NJAC 8:39-9.4(e)	F 609		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews, medical records (MR), and other pertinent facility documentation on 10/4/2023,10/5/2023, 10/6/2023, and 10/11/23, it was determined that the facility failed to adequately supervise a resident with a known history of Ex Order 26. 4B1 and follow the facility policy titled "Ex Order 26. 4B1" for 1 of 1 resident (Resident #4) reviewed for incident and accident. This deficient practice was evidenced by: According to the Admission Record (AR), Resident #4 was admitted to the facility on Ex Order 26. 4B1, with diagnoses that included but were not limited to Ex Order 26. 4B1.	F 689	IMMEDIATE ACTION On 10/6/2023, Resident # 4□s Ex Order 26. 4B1 was updated to include for staff to stay with resident during mealtime, NJ Exec. Order 26:4.b.1 and assist if needed. In addition, Resident #4□s care plan on NJ Exec. Order 26:4.b.1 was reviewed and updated to monitor resident every 15 minutes for NJ Exec. Order 26:4.b.1 and environmental assessment for safety to be done daily by housekeeping during room cleaning to ensure there is NJ Exec. Order 26:4.b.1 in the room on 10/6/2023. Maintenance Director assessed the bed remote cord to ensure the NJ Exec. Order 26:4.b.1 on 10/6/23. RN # 1 was given education on 10/6/2023	11/20/23

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F 689	Continued From page 5 The Minimum Data Set (MDS), an assessment tool dated NJ Exec. Order 26:4.b.1 Resident #4 had a Brief Interview for Mental Status (BIMS) score of Ex Order /15, which indicated the resident was Ex Order 26. 4B1. The MDS also indicated Resident #4 needed help in Ex Order 26. 4B1 and was NJ Exec. Order 26:4.b.1 herself/himself. A review of Resident #4's Care Plan (CP) initiated on NJ Exec. Order 26:4.b, indicated that Resident #4 had Ex Order 26. 4B to the staff, Ex Order 26. 4B1, and Ex Order 26. 4B1. The CP initiated on NJ Exec. Order 26, revealed that Resident #4 had NJ Exec. Order 26:4.b.1 as evidenced by NJ Exec. Order 26:4.b.1 at staff. A review of Resident #4's progress notes (PN) dated NJ Exec. Order 26:4.b at 3:32 p.m. was documented by a Registered Nurse (RN #1). The PN indicated that during morning care, Resident #4 had Ex Order 26. 4B1 by verbalizing 'Ex Order 26. 4B1." The PN indicated that the tray was delivered, and after lunch, during the collection of the trays, RN #1 responded to Resident #4 who was yelling and calling for a nurse for an emergency. Resident #4 reported that she/he Ex Order 26. 4B1 with the butter knife. The PN indicated that the Ex Order 26. 4B1, the Nurse Practitioner, and the family member were notified, and Resident #4 was transferred to the Ex Order 26. 4B1 for further NJ Exec. Order 26:4.b.1.	F 689	on the facility policy and procedure on Suicidal Ideation by Assistant Director of Nursing for Pediatrics emphasizing that if any resident expresses suicidal ideation such as but not limited to not wanting to live or want to die, staff must stay with resident within arm's length until 1:1 is assigned and remove all harmful/injurious items such as bed cord, butter knife, any sharp items immediately and report. IDENTIFY OTHERS: On 10/6/2023, All residents that has the potential to be affected by the same deficient practice was reviewed by unit managers/designee and no negative findings were found. INSERVICES: On 10/6/2023, the policy on Suicidal Ideation was reviewed by facility's Interdisciplinary Team and found to be compliant. On 10/6/2023 in-service on Suicidal Ideation was initiated to all staff including agencies by facility to emphasize that if any resident expresses suicidal ideation such as but not limited to not wanting to live or want to die, staff must stay with resident until 1:1 is assigned and remove all harmful/injurious items such as bed cord, butter knife, any sharp items immediately and report. In-service was completed by 10/8/2023. QAPI: Director of Nursing/designee will perform weekly audits on suicidal ideation education for the first 3 months then quarterly thereafter. The Maintenance	

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F 689	Continued From page 6 There was no indication in the MR that Resident #4 was being monitored and interventions were put in place on NJ Exec. Order 26:4.b.1 to NJ Exec. Order 26:4.b.1 herself/himself when he/she had Ex Order 26. 4B1 according to the facility policy. On NJ Exec. Order 26:4.b.1 at 4:02 p.m., it was documented by Resident #4's PCP that Resident #4 became NJ Exec. Order 26:4.b.1 and had a Ex Order 26. 4B1 . The PCP further documented that Resident #4 was transferred to the Ex Order 26. 4B1 for further NJ Exec. Order 26:4.b.1 and a possible Ex Order 26. 4B1 management. On NJ Exec. Order 26:4.b.1 at 9:02 p.m., documented by Resident #4's Ex Order 26. 4B1 , the Ex Order 26. 4B1 wrote "Resident was seen for an individual Ex Order 26. 4B1 to address a very recent incident of NJ Exec. Order 26:4.b.1 Ex Order 26. 4B1 superficially with a NJ Exec. Order 26:4.b.1 ." The resident was sent to the Ex Order 26. 4B1 for NJ Exec. Order 26:4.b.1 A review of Resident #4's Ex Order 26. 4B1 dated NJ Exec. Order 26:4.b.1 indicated that Resident #4 NJ Exec. her/his Ex Order 26. 4B1 with a NJ Exec. Order 26 and was transferred to the Ex Order 26. 4B1 for a Ex Order 26. 4B1 . The Hospital record (HR) revealed that Resident #4 arrived at the hospital on NJ Exec. Order 26:4.b.1 at 4:27 p.m. The HR indicated that Resident #4 was evaluated by the Ex Order 26. 4B1 and noted to have a medical history of Ex Order 26. 4B1 and was presented to the emergency department for Ex Order 26. 4B1 . The HR further indicated that Resident #4 presented with "Ex Order 26. 4B1 NJ Exec. Order 26 self Ex Order 26. 4B1 with a NJ Exec. Order 26:4.b.1 ." Resident #4 stated she/he was upset with the staff for not helping her/him get	F 689	Director/designee will perform weekly audits on bed remote control cord weekly for the first 3 months and then quarterly thereafter. Housekeeping Director/designee will perform weekly audit on environmental safety for the first 3 months then weekly thereafter. Any negative findings will have immediate corrective actions taken by Director of Nursing and reported to the Administrator. All findings of the audits will be presented during the QAPI meetings held quarterly by the Director of Nursing/designee and will be ongoing until 100 percent compliant attained.	

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F 689	Continued From page 7 into a Ex Order 26 chair to join an activity, she/he was upset and yelled so Ex Order used the NJ Exec. Order 26:4.b.1 of the staff. On 09/01/2023 at 12:40 a.m., documented by RN #2, Resident #4 returned to the facility and provided Ex Order NJ Exec. Order 26:4.b.1 for the night. The surveyor conducted the interview with the Social Workers (SW #1 and SW #2) on 10/6/23 at 10:01 a.m. The SWs were not aware of Resident's Ex Order 26. 4B1 on NJ Exec. Order 26:4.b. SW #1 stated that she was made aware of the incident after Resident #4 had Ex Order 26. 4B1 herself/himself. According to SW #1, she had to be notified of any forms of Ex Order 26. 4B1. SW #1 explained that when there is a Ex Order 26. 4B1 the resident had to be NJ Exec. Order 26:4.b.1, to stay with the resident so that they would not have the opportunity to execute the Ex Order 26. 4B1, to remove any NJ Exec. Order 26:4.b.1. The surveyor conducted the interview with the Restorative CNA (RCNA) on 10/6/23 at 10:43 a.m. The RCNA stated that she did not provide supervision and/or any care to Resident #4. She explained that on NJ Exec. Order 26:4.b. she dropped off the Resident's tray and left and did not see anyone inside the resident's room. The RCNA confirmed that the Resident's Ex Order 26. 4B1 was not communicated to her. The surveyor conducted an interview with the Charge Nurse LPN (CNLPN) on 10/6/23 at 11:09 a.m. The CNLPN stated that RN #1 reported that Resident #4 NJ Exec. Order 26:4.b.1. The CNLPN further stated that after the incident, she instructed RN #1 to call the PCP and ask an aide to stay with the resident. However, according to	F 689		

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F 689	Continued From page 8 CNLPN, she was never made aware that the Resident had Ex Order 26. 4B1 before NJ Exec. Order 26:4.b.1 her/his Ex Order 26. 4 The surveyor conducted the interview with RN #1 on 10/6/23 at 1:46 and 3:15 p.m. RN #1 confirmed what was written on the PN dated NJ Exec. Order 26:4.b.1. RN #1 further stated that she did not provide Ex Order 26. 4B1 after Resident #4 had the Ex Order 26. 4B1, instead, she stayed outside Resident #4's room (measuring 11 feet and 5 inches apart) looking at the computer and did not communicate with other staff members in the unit of Resident #4 Ex Order 26. 4B1. RN #1 further stated that when RCNA delivered the lunch tray, she did not NJ Exec. Order 26:4.b.1 that the Resident could use to NJ Exec. Order 26:4.b.1. According to RN #1, she should have removed and/or stayed close (an arm length) with the resident to prevent her/him from NJ Exec. Order 26:4.b.1. However, the RN admitted that the resident used a NJ Exec. Order 26 and the resident was allowed to have a NJ Exec. Order 26:4.b.1 delivered from the kitchen. The surveyor conducted an interview with ADON #2 and LNHA on 10/11/23 at 12:05 p.m., they stated that Resident #4's abovementioned incident was considered a Ex Order 26. 4B1, and staff were expected to initiate the facility policy on Ex Order 26. 4B1 protocol. A review of the facility's policy titled "SUICIDAL RESIDENTS," undated, indicated "POLICY Every suicide threat and/or attempt will be acted upon to prevent intentional or accidental suicides from occurring...2. When you determine there is clear intent on the resident's part, check the resident's	F 689		

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F 689	Continued From page 9 environment for potential hazards. 3. Assign a staff member for one to one observation, and to stay within the distant of an arm length of the resident until determination of the course of treatment has been made by a physician...4. Notify the attending physician, administrator, DON and the director of social work, of resident's potential for suicides and details if the resident has expressed a suicidal plan..." NJAC 8:39-27.1(a)	F 689		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F 842		11/20/23

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F 842	Continued From page 10 (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315229	A. BUILDING ______ B. WING ______	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX CENTER FOR REHABILITATION AND PEDIATRICS	1433 RINGWOOD AVE HASKELL, NJ 07420

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F 842	Continued From page 11 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: C #: 167992 Based on interviews, medical record review, and review of other pertinent facility documents on 10/4/23, 10/5/23, 10/6/23 and 10/11/23, it was determined that the facility staff failed to accurately document in the Treatment Administration Record (TAR) that the care was provided to the resident according to the facility protocol for 1 of 3 residents (Resident #1) reviewed for documentation. This deficient practice was evidenced by the following: 1. According to the facility "Admission Record (AR)," Resident #1 was admitted on Ex Order 26. 4B1, with diagnosis that included but were not limited to: Ex Order 26. 4B1. The Minimum Data Set (MDS), an assessment tool, dated NJ Exec. Order 26:4.b. revealed a Brief Interview of Mental Status (BIMS) of Ex Ord which indicated the resident's cognition was Ex Order 26. 4B1 and the resident needed assistance with Ex Order 26. 4B1 . Review of Resident #2's Order Summary Report reflected an order for Ex Order 26. 4B1 site NJ Exec. Order 26:4.b.1 every day shift on Thursday. The TAR for NJ Exec. Order 26 confirmed the aforementioned ordered. However, on NJ Exec. Order 26:4.b the TAR indicated a code "Ex", meant to check the progress notes.	F 842	IMMEDIATE ACTION On 10/6/2023, the treatment that was rendered by LPN #5 for resident #1 on 8/24/2023 was corrected on resident's TAR to reflect treatment provided. On 10/6/2023, LPN #5 was re-educated by Assistant Director of Nursing for Pediatrics on the policy on General Documentation to ensure all treatments rendered are documented accurately on residents TAR. IDENTIFY OTHERS: On 10/6/2023, All residents that has the potential to be affected by the same deficient practice were reviewed by unit manager/designee to ensure all documentations are entered accurately on TAR. No negative findings were found. INSERVICES: On 10/6/2023, the policy on General Documentation was reviewed by facility's Interdisciplinary Team and found to be compliant. On 10/6/2023 in-service on General Documentation was initiated to all nursing staff including agencies by Assistant Director of Nursing/designee to ensure all treatments are documented accurately on resident's TAR and will be ongoing until 100% compliant. QAPI: Assistant Director of Nursing/designee will perform weekly audits on TAR documentation for the first three months	

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F 842	Continued From page 12 Review of the Resident's PN, there was no indication that the aforementioned order was provided to Resident #1. During an interview with the surveyor in the presence of ADON #2 on 10/4/23 at 1:00 p.m., the Licensed Practical Nurse LPN #5 stated that Resident #1's aforementioned treatment was rendered, however, she made a mistake. Review of the facility policy "General Documentation," dated 1/5/23, under "POLICY: The clinical team shall document all relevant data and information pertaining to the provision of care and services to the residents in the medical record. Any and all forms of documentation by a clinician should be recorded according to accepted professional standards of practice.... Failure to keep and maintain certain documentations as required by regulatory agencies, falsifying documentation, and incomplete or inaccurate documentation, may be found to constituent and professional conduct...3. documentation must be clear, concise, the secretive, accurate, and comprehensive... documentation should be recorded both the action taken by the clinical staff the residents needs and/or response to illness and the care they receive. It should be a full account of the clinician's assessment and care provider..." NJAC 8:39-35.2(d)(9)	F 842	then quarterly thereafter. Any negative findings will have immediate corrective actions taken by the Director of Nursing and reported to the Administrator. All findings of the audits will be presented during the QAPI meetings held quarterly by the Assistant Director of Nursing and will be ongoing until 100 percent compliant is attained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061628	A. BUILDING: ____ B. WING ____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX CENTER FOR REHABILITATION AND	1433 RINGWOOD AVE HASKELL, NJ 07420

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S 000	Initial Comments COMPLAINT #: Survey Dates: 10/4/23, 10/5/23, and 10/6/23 NJ166871 NJ167992 NJ168034 CENSUS: 198 SAMPLE SIZE: 4 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: NJ166871 NJ167992 NJ168034 Based on the facility document review, it was	S 560	IMMEDIATE ACTION There were no care issues reported on the 25 shifts out of 28 shifts that were reviewed on 10/6/2023	11/20/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/03/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061628	A. BUILDING: ______ B. WING ______	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 1 determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios mandated by the state of New Jersey for 25 of 28 day shifts reviewed. 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. For the 2 weeks of Complaint staffing from 08/27/2023 to 09/09/2023, the facility was deficient in CNA staffing for residents on 12 of 14-day shifts as follows: -08/27/23 had 5 CNAs for 101 residents on the day shift, which required at least 13 CNAs. -08/28/23 had 10 CNAs for 101 residents on the	S 560	IDENTIFY OTHERS: Director of Nursing/designee reviewed the last 30 days of CNA staffing report. Staffing needs were partially met by the facility. Recruitment efforts are in place to assist the facility in recruiting. CNAs receives sign on bonus, referral bonus, reimbursement for C.N.A. tuition, and transportation service from certain locations. Facility is also has increased the rates for C.N.As within the year. Facility also has contracts with Agencies to recruit C.N.As. Facility is also working on getting a C.N.A. school approved. Director of Nursing/designee also reviewing staff attendance records to ensure that excessive absences are addressed accordingly. INSERVICES: On 10/6/2023, Administrator in-serviced the Director of Nursing/Nursing Management and Staffing Coordinator regarding the requirement for S560 to ensure C.N.A. staffing needs are reviewed daily and addressed as needed to meet the staffing requirement. QAPI: Director of Nursing/designee will review staffing reports daily and perform weekly audits on C.N.A. staffing levels for the first 3 months then quarterly thereafter. Any negative findings will have immediate corrective actions taken by Director of Nursing/designee and reported to the Administrator. All findings of the audits will be presented during the QAPI meetings held quarterly by the Director of Nursing	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061628	A. BUILDING: ______ B. WING ______	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 2 day shift, which required at least 13 CNAs. -08/29/23 had 11 CNAs for 101 residents on the day shift, which required at least 13 CNAs. -08/30/23 had 11 CNAs for 101 residents on the day shift, which required at least 13 CNAs. -08/31/23 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. -09/02/23 had 8 CNAs for 100 residents on the day shift, which required at least 12 CNAs. -09/03/23 had 9 CNAs for 102 residents on the day shift, which required at least 13 CNAs. -09/04/23 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -09/05/23 had 10 CNAs for 101 residents on the day shift, which required at least 13 CNAs. -09/07/23 had 9 CNAs for 101 residents on the day shift, which required at least 13 CNAs. -09/08/23 had 10 CNAs for 1003 residents on the day shift, which required at least 13 CNAs. -09/09/23 had 10 CNAs for 103 residents on the day shift, which required at least 13 CNAs. For the 2 weeks of staffing prior to the survey from 09/17/2023 to 09/30/2023, the facility was deficient in CNA staffing for residents on 13 of 14-day shifts as follows: -09/17/23 had 7 CNAs for 105 residents on the day shift, which required at least 13 CNAs. -09/18/23 had 8 CNAs for 104 residents on the day shift, which required at least 13 CNAs. -09/19/23 had 10 CNAs for 103 residents on the day shift, which required at least 13 CNAs. -09/20/23 had 10 CNAs for 101 residents on the day shift, which required at least 13 CNAs. -09/21/23 had 8 CNAs for 103 residents on the day shift, which required at least 13 CNAs. -09/22/23 had 10 CNAs for 103 residents on the day shift, which required at least 13 CNAs.	S 560	and will be ongoing until 100 percent compliant attained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 3 -09/23/23 had 9 CNAs for 106 residents on the day shift, which required at least 13 CNAs. -09/24/23 had 8 CNAs for 104 residents on the day shift, which required at least 13 CNAs. -09/25/23 had 11 CNAs for 104 residents on the day shift, which required at least 13 CNAs. -09/27/23 had 12 CNAs for 104 residents on the day shift, which required at least 13 CNAs. -09/28/23 had 8 CNAs for 104 residents on the day shift, which required at least 13 CNAs. -09/29/23 had 9 CNAs for 104 residents on the day shift, which required at least 13 CNAs. -09/30/23 had 9 CNAs for 104 residents on the day shift, which required at least 13 CNAs.	S 560		

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)
315229	A. Building B. Wing	12/4/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX CENTER FOR REHABILITATION AND PEDIATRICS	1433 RINGWOOD AVE HASKELL, NJ 07420

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 F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 11/20/2023	ID Prefix F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 11/20/2023	ID Prefix F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 11/20/2023
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	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	
10/6/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061628 Y1	A. Building B. Wing Y2	12/4/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX CENTER FOR REHABILITATION AND PEDIATRICS	1433 RINGWOOD AVE HASKELL, NJ 07420

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 11/20/2023	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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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 10/6/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO