STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315522	A. BUILDING _____ B. WING _____	C 02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILES AVE & STERLING DR URBAN RENEWAL OPRATIONS L	10 STERLING DRIVE PISCATAWAY, NJ 08854

(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 #: NJ00167535, NJ00167908, and NJ00170353 Survey Dates: 2/15/24 Census: 58 Sample Size: 6 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 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		3/26/24

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

Electronically Signed | 03/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315522	A. BUILDING _____ B. WING _____	C 02/15/2024

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SKILES AVE & STERLING DR URBAN RENEWAL OPRATIONS L	10 STERLING DRIVE PISCATAWAY, NJ 08854

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F 623	Continued From page 1	F 623		

discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual

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	315522	A. BUILDING _____ B. WING _____	C 02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 623	Continued From page 2 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: COMPLAINT #NJ00170353 Based on interview, medical record review, and	F 623	This Plan of Correction constitutes the facility's credible allegation of compliance. 1) How the Corrective action will be accomplished for the residents found to	

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	315522	A. BUILDING _____ B. WING _____	C 02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILES AVE & STERLING DR URBAN RENEWAL OPRATIONS L	10 STERLING DRIVE PISCATAWAY, NJ 08854

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F 623	Continued From page 3 review of other pertinent facility documents on 2/15/24, it was determined that the facility failed to provide written notice of discharge to the resident, resident representative, and the Office of the Long-Term Care Ombudsman (LTCO) for 3 of 3 residents (Resident #3, Resident #5, and Resident #6), reviewed for facility-initiated discharges. This deficient practice was evidenced by the following: 1.) The surveyor reviewed the medical records of Resident #3. Review of the Resident #3's Admission Record (AR) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ EX Order, 264b1 [redacted] Review of Resident #3's Progress Notes (PN) revealed the following: [redacted] Physician Note that indicated that a discharge summary was completed -[redacted] Nursing Notes that indicated that the resident was discharged to another facility. Review of Resident #3's the Discharge Minimum Data Set, an assessment tool used to facilitate the management of care, dated [redacted] indicated that the resident had a discharge assessment with "return not anticipated." Review of Resident #3's electronic medical record (EMR) did not include a notification letter	F 623	have been affected Resident # 3 returned to the facility. Resident #5 and #6 did not return to the center. No negative outcome has occurred from this practice. 2)How the facility will identify other residents having the potential to be affected All Residents have the potential to be affected by this practice. 3) What measures will be put into place or systematic changes made to ensure the deficient practice will not recur The Business Office/SS Staff will have been in-serviced on the transfer/discharge policy and procedure to include notifying resident and the resident representative of the transfer or discharge. Business Office Manager/SS designee will update the monthly discharge tracking list on a daily basis. A notice of transfer from the facility with the list of residents/patients will be submitted to the Office of the Ombudsman on a monthly basis. 4)How the facility will monitor its corrective actions to ensure compliance The Business Office Manager/SW Designee will audit all transfer/discharges from the facility weekly x 4 weeks then	

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	315522	A. BUILDING _____ B. WING _____	C 02/15/2024

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F 623	Continued From page 4 to the resident, resident representative, and the LTCO of the facility-initiated discharge. 2.) The surveyor reviewed the medical records of Resident #5. Review of the Resident #5's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted]. Review of Resident #5's PN revealed a progress note that indicated that the resident was transferred to another facility. Review of Resident #5's MDS, dated [redacted], indicated that the resident had a discharge assessment with return not anticipated. Review of Resident #5's electronic medical record (EMR) did not include a notification letter to the resident, resident representative, and the LTCO of the facility-initiated discharge. 3.) The surveyor reviewed the medical records of Resident #6. Review of the Resident #6's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted]. Review of Resident #6's Progress Notes (PN)	F 623	monthly x 2 months The Business Office Manager/SW Designee will report findings to the QAPI Committee monthly for 3 months or until substantial compliance is achieved and determine if further monitoring and evaluation is required.	

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F 623	Continued From page 5 revealed the following: - [redacted] Physician Note that indicated that a discharge summary was completed. - [redacted] Nursing Note that indicated that the resident was discharged to another facility. Review of Resident #6's MDS, dated [redacted] indicated that the resident had a discharge assessment with return not anticipated. Review of Resident #6's electronic medical record (EMR) did not include a notification letter to the resident, resident representative, and the LTCO of the facility-initiated discharge. On 02/15/24 at 2:20 P.M., the surveyor interviewed the Administrator who stated that the facility is to provide thirty-day notice to a resident, and/or the resident's representative, as well as the LTCO in the event of a facility-initiated discharge. The surveyor asked the Administrator to provide proof of notification of discharge for Resident #3, Resident #5, and Resident #6. The Administrator stated that he would investigate further. No additional information was provided to this surveyor during the survey. Review of the facility's "OPS404 Discharge and Transfer" policy, dated [redacted], indicated "A Notice of Involuntary Discharge (NOID) must be provided at least 30 days in advance of a proposed involuntary discharge (facility initiated)." NJAC 8:39-4.1(a)32; 5.4	F 623		

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	12056	A. BUILDING: _____ B. WING _____	C 02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILES AVE & STERLING DR URBAN RENEWAL OPR	10 STERLING DRIVE PISCATAWAY, NJ 08854

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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 26 of 28 day shifts as 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	S 560	1. How the Corrective action will be accomplished for the residents found to have been affected All residents present in the facility were not affected by the deficient practice on the dates and shifts noted. 2. How the facility will identify other residents having the potential to be affected All residents have the potential to be affected by this deficient practice 3. What measures will be put into place or systematic changes made to ensure the	3/26/24

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

Electronically Signed | 03/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12056	A. BUILDING: _____ B. WING _____	C 02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 1 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 12/31/2023 to 01/13/2024, and 01/28/2024 to 02/10/2024, 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 shifts as documented below: 1. For the week of staffing from 12/31/2023 to 01/13/2024, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -12/31/23 had 4 CNAs for 46 residents on the day shift, required at least 6 CNAs. -01/01/24 had 3 CNAs for 46 residents on the day shift, required at least 6 CNAs. -01/02/24 had 4 CNAs for 46 residents on the day	S 560	deficient practice will not recur DON/ NHA and staffing coordinator were re educated on NJ staffing mandate Center will continue recruiting functions, which drive various forms of media to increase the number of applicants and Weekly Staffing calls with regional support team 4. How will the facility monitor its corrective actions to ensure compliance The DON, staffing coordinator and HR coordinator/designee will maintain a listing of current recruiting efforts, and document 3 days a week the results of these efforts. The Administrator will audit these efforts weekly x 4 weeks then monthly x 2 months to ensure the Center team is following up on all recruitment tasks. The Administrator /DON or Designee will report findings to the Performance Improvement Committee monthly for three months. The Performance Improvement Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required.	

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S 560	Continued From page 2 shift, required at least 6 CNAs. -01/04/24 had 4 CNAs for 43 residents on the day shift, required at least 5 CNAs. -01/05/24 had 3 CNAs for 43 residents on the day shift, required at least 5 CNAs. -01/06/24 had 4 CNAs for 43 residents on the day shift, required at least 5 CNAs. -01/07/24 had 5 CNAs for 48 residents on the day shift, required at least 6 CNAs. -01/08/24 had 5 CNAs for 48 residents on the day shift, required at least 6 CNAs. -01/09/24 had 3 CNAs for 48 residents on the day shift, required at least 6 CNAs. -01/10/24 had 5 CNAs for 54 residents on the day shift, required at least 7 CNAs. -01/11/24 had 4 CNAs for 54 residents on the day shift, required at least 7 CNAs. -01/12/24 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs. -01/13/24 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs. 2. For the week of staffing from 01/28/2024 to 02/10/2024, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -01/28/24 had 5 CNAs for 60 residents on the day shift, required at least 7 CNAs. -01/29/24 had 6 CNAs for 59 residents on the day shift, required at least 7 CNAs. -01/30/24 had 6 CNAs for 59 residents on the day shift, required at least 7 CNAs. -01/31/24 had 5 CNAs for 59 residents on the day shift, required at least 7 CNAs. -02/01/24 had 6 CNAs for 59 residents on the day shift, required at least 7 CNAs. -02/03/24 had 6 CNAs for 60 residents on the day shift, required at least 7 CNAs.	S 560		

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 -02/04/24 had 6 CNAs for 60 residents on the day shift, required at least 7 CNAs. -02/05/24 had 6 CNAs for 58 residents on the day shift, required at least 7 CNAs. -02/06/24 had 4 CNAs for 54 residents on the day shift, required at least 7 CNAs. -02/07/24 had 5 CNAs for 54 residents on the day shift, required at least 7 CNAs. -02/08/24 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs. -02/09/24 had 5 CNAs for 54 residents on the day shift, required at least 7 CNAs. -02/10/24 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
12056 Y1	A. Building B. Wing Y2	3/27/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILES AVE & STERLING DR URBAN RENEWAL OPRATIONS L	10 STERLING DRIVE PISCATAWAY, NJ 08854

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 03/26/2024	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	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	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	
2/15/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315522	A. Building B. Wing	3/27/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILES AVE & STERLING DR URBAN RENEWAL OPRATIONS L	10 STERLING DRIVE PISCATAWAY, NJ 08854

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 F0623 Reg. # 483.15(c)(3)-(6)(8) LSC	Correction Completed 03/26/2024	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	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	
2/15/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO