STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315461	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN REHABILITATION AND HEALTHCARE CENTER	100 LONG-A-COMING LANE , BERLIN, New Jersey, 08009

(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
F0000	INITIAL COMMENTS COMPLAINT #: 2592172 CENSUS: 121 SAMPLE SIZE: 3 A complaint survey was conducted on 08/19/2025 and 08/25/2025, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. During a survey on 08/19/2025, a finding which constituted an immediate Jeopardy (IJ) was identified under 42 CFR 483.25 (d)(2) F 689, when the facility failed to provide NJ Exec Order 26.4b1 to a NJ Exec Order 26.4b resident (Resident #2) with a history of NJ Exec Order 26.4b1 who NJ Exec Orde from the facility on NJ Exec Order 26.4b1 at approximately 6:01 P.M. This occurred when the US FOIA US FOIA (b)(6) who confirmed that she observed the resident NJ Exec O the facility wearing a NJ Exe and using a NJ Exec Orde "assumed" the person was a visitor and did not stop them from going out through the facility's main entrance door. The US FOIA (b)(6) also stated that she did not hear the NJ Exec Order 26.4b1 when the resident NJ Exec Orde from facility. When the US FOIA (b)(6)) was interviewed on 08/19/2025, she stated that the facility was not sure how Resident #2 NJ Exec Order 26.4b1 since their systems were functioning on the day the resident NJ Exec Order Staff became aware that the resident was NJ Exec Order 2 when another staff member called Resident #2's unit and spoke with the Licensed Practical Nurse (LPN #1) and informed her that another staff saw someone that looked like a resident NJ Exec Order 26.4b1 when he was returning to the facility from his dinner break. At that time, LPN #1 attempted to NJ Exec Orde Resident #2 in their room but NJ Exec Order 26.4b1. LPN #1 and other staff members went NJ Exec Order in NJ Exec Orde of Resident #2. Some staff members including the US FOIA drove out in NJ Exec Orde of the resident. According to the US FOIA during an interview on 08/19/2025 at 2:49 P.M., staff NJ Exec Orde the resident 30 minutes later, where the resident was NJ Exec Order 26.4b1 and NJ Exec Orde the resident NJ Exec O to the NJ Exec Orde at approximately 6:49 P.M.	F0000		09/09/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315461	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/25/2025

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F0000	Continued from page 1 The facility's failure to provide NJ Exec Order 26.4b1 for Resident #2 placed Resident #2, and all other residents who NJ Exec Order or have NJ Exec Order 26.4b1, at risk for NJ Exec Order 26.4b which posed the likelihood for serious harm, injury, impairment or death. This resulted in an Immediate Jeopardy (IJ) situation. The facility's US FOIA (b)(6) was notified of the F 689 IJ and was provided the IJ template on 08/19/2025 at 6:28 P.M. The IJ was Past Non-Compliance (PNC). The facility submitted an acceptable Removal Plan (RP) on 08/21/2025 at 12:00 P.M., indicating the actions the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: the facility NJ Exec Order the resident and immediately NJ Exec Order 26.4b1 to the facility. Resident #2 was placed on NJ Exec Order 26.4b1 ; their care plan was revised; and the functioning of their NJ Exec Order 26.4b1 was verified. The facility completed a head count to verify all residents were accounted for; conducted a house sweep using an 'NJ Exec Order 26.4b1 to check other residents for NJ Exec Order 26.4b risk; educated all staff on interventions to prevent NJ Exec Order 26.4b1 and verified all binders that identified residents at risk for NJ Exec Order 26.4b were accurate and placed at the nurses' stations and the front desk. The NJ Exec Order 26.4b1 policy was reviewed, and the US FOIA (b)(6) and off-shift staff were educated on the process for incoming and departing visitors. The Regional Plant Operations inspected doors and NJ Exec Order 26.4b1 ; the door lock system was reviewed, and the timer was adjusted; adjustment was made to the frequency/sensitivity for the NJ Exec Order ; and the front door system was switched to alert the front door's operator with a push/release mode only. The facility self-corrected the deficient practice, and it was determined that the IJ was PNC. The facility corrected their non-compliance on 08/17/2025. The surveyor verified the implementation of the Removal Plan on-site on 08/25/2025.	F0000		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F0689	"Past Noncompliance - no plan of correction required"	09/09/2025

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F0689 SS = SQC-J	Continued from page 2 §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, review of medical records, and other pertinent facility documentation on 08/19/2025, it was determined that the facility failed to provide NJ Exec Order 26.4b1 to a NJ Exec Order 26.4b1 resident (Resident #2) with a known history of NJ Exec Order 26.4b who NJ Exec Orde from the facility on NJ Exec Order 26.4b1 The deficient practice was identified for 1of 3 residents (Resident #2). The resident had a history of NJ Exec Orde their unit on NJ Exec Order 26.4b1 On NJ Exec Order 26.4b1 at approximately 6:01 P.M., Resident #2, while wearing a NJ Exec Order 26.4b1 , NJ Exe their unit on the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 through the main lobby front door. Staff became aware that the resident was NJ Exec Order from their unit when another nurse informed Resident #2's Licensed Practical Nurse (LPN #1) that when a staff member was coming into the facility, he NJ Exec Order 26.4b1 Resident #2 NJ Exec Order 26.4b1 . At that time, LPN #1 NJ Exec Orde for Resident #2 in their NJ Exec Orde but NJ Exec O . LPN #1 and other staff members went outside to NJ Exec Orde for the resident. Resident #2 was NJ Exec O approximately thirty minutes later, while NJ Exec Order and NJ Exec Order NJ Exec Order 26.4b1 at approximately 6:49 P.M. The facility's failure to provide NJ Exec Order 26.4b1 to a NJ Exec Order 26.4b1 resident who was at risk for NJ Exec Order 26.4b and NJ Exec Orde posed a likelihood of serious harm, injury, impairment, or death. This resulted in an Immediate Jeopardy (IJ) situation which ran from NJ Exec Order 26.4b1 at 6:01 P.M., when Resident #1 NJ Exec Orde from the facility out of the main entrance doors until NJ Exec Order 26.4b1 at 6:49 P.M., when the resident was NJ Exec Order by staff and NJ Exec Order 26.4b1 The IJ was Past Non-Compliance (PNC). The facility's Administration was notified on the IJ on 08/19/2025 at 6:28 P.M. The facility submitted an acceptable Removal Plan on 08/21/2025. The facility was back in compliance when the facility addressed the situation by NJ Exec Order the resident and	F0689		

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F0689 SS = SQC-J	Continued from page 3 immediately [redacted]. Resident #2 was placed on [redacted]; their care plan was revised; and the functioning of their [redacted] was verified. The facility completed a head count to verify all residents were accounted for; conducted a house sweep using an "[redacted]" to check other residents for [redacted] risk; educated all staff on interventions to prevent [redacted] and verified all binders that identified residents at risk for [redacted] were accurate and placed at the nurses' stations and the front desk. The [redacted] policy was reviewed, and the [redacted] and off-shift staff were educated on the process for incoming and departing visitors. The Regional Plant Operations inspected doors and [redacted] functionality; the door lock system was reviewed, and the timer was adjusted; adjustment was made to the frequency/sensitivity for the [redacted] and the front door system was switched to alert the front door's operator with a push/release mode only. The surveyor verified the completion of the Removal Plan was 08/17/2025, during the on-site visit on 08/25/2025, and determined the IJ was PNC. The evidence was as follows: A review of the facility's policy titled "Wander Management and Prevention" Updated-March 2022, under "Policy Statement" Indicated: "The facility will maintain the safety of residents who wander and/or are at risk for elopement." Under "Policy Interpretation and Implementation" 4. "The wander management system device will be used in conjunction with other resident-specific interventions for the management of unsafe wandering. 5b. Wander management system devices will be checked for functionality daily by nursing staff. 7. Doors with wander management system alarms will be checked for functionality daily by maintenance staff/designee. 8. Identified issues with wander management system alarms will be immediately addressed." A review of the facility's policy titled "Wandering and Elopements" under "Policy Interpretation and Implementation" 2. "If an employee observes a resident leaving the premises, he/she should: a. attempt to prevent the resident from leaving in a courteous manner; b. get help from other staff members in the immediate vicinity, if necessary and c. Instruct another staff member to inform the charge nurse or director of nursing services that a resident is attempting to leave or has left the premises."	F0689		

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F0689 SS = SQC-J	Continued from page 4 According to the Facility Reportable Event Record (FRE) dated [redacted], Resident #2 [redacted] the [redacted] nursing unit and [redacted] out of the facility through the facility's [redacted] at 6:01 P.M. According to the FRE, the [redacted] on duty at the time confirmed that she observed Resident #2 [redacted] the building through the main front door but thought the resident was a visitor because the resident wore a [redacted]. The FRE indicated that at around 6:22 P.M., a staff member who was returning to facility from his dinner break informed the nurse on the [redacted] unit that he saw a person with a [redacted], like a resident. Staff then [redacted] for Resident #2 in their [redacted] but [redacted] the resident. A [redacted] was called, and a [redacted] was initiated for the resident. The "Summary and Conclusion" of the FRE indicated that staff [redacted] Resident #2 on the [redacted] and [redacted] the resident to facility at 6:49 P.M., and that the resident's vital signs, [redacted] and [redacted] evaluation were completed, and [redacted] noted; and that facility placed Resident #2 on [redacted]. According to the Admission Record (AR), Resident #2 was admitted to the facility with diagnoses which included but were not limited to: [redacted]. According to the quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident's [redacted] was [redacted]. The MDS also indicated that Resident #2 had an [redacted], and that the resident [redacted]. The surveyor reviewed Resident #2's Progress Notes (PN) dated [redacted] at 2:29 P.M., Note Text: Late entry for [redacted], written by the [redacted] The PN revealed that staff was notified that Resident #2 [redacted] and that the staff immediately responded by going to [redacted]. The PN further stated that staff [redacted] the resident and [redacted] to the facility, and that the resident's family and the physician were notified. According to Resident #2's Care Plan (CP) with an initiated date of [redacted], Resident #2 was at actual/potential risk for [redacted] The CP also	F0689		

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F0689 SS = SQC-J	Continued from page 5 reflects NJ Exec Order 26.4b1 that was initiated on NJ Exec Order 26.4b1 with an intervention to maintain NJ Exec Order [redacted] and function. The CP also revealed the following interventions: photograph in NJ Exec Order 26.4b book - initiated on NJ Exec Order 26.4b1, monitor for resident's NJ Exec Order 26.4b1 initiated on NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 initiated NJ Exec Order 26.4b1 On 08/19/2025 at 10:23 A.M., the surveyor conducted a telephone interview with the US FOIA (b)(6) who was on duty at the facility's front entrance on NJ Exec Order 26.4b1. The US FOIA (b)(6) stated that on NJ Exec Order 26.4b1, she observed a person going through the front entrance maybe around 6:00 P.M., NJ Exec Order 26.4b1 [redacted]. She stated she thought the person was a visitor because she did not see their face. The US FOIA (b)(6) stated she was familiar with Resident #2, and added that the resident NJ Exec Order 26. and had a NJ Exec Order 26.4b1. The US FOIA (b)(6) stated that they had a binder at the front desk for residents at risk for NJ Exec Order 26.4b with each resident's name, room number and their pictures in the binder. When asked if she checked the binder, she said she tried to make it a habit to check the binder and that they received information when the binder was updated. The US FOIA (b)(6) further stated she did not hear the NJ Exec Order 26.4b1 on the day Resident #2 NJ Exec Orde through the facility's front lobby entrance. On 08/19/2025 at 10:55 A.M., during an interview with the surveyor, LPN #2, who was assigned to Resident #2, stated LPN #1 informed her that she received a phone call from the nurse downstairs who informed her that a staff reported he saw NJ Exec Order 26.4b1 [redacted] resident at the facility, but he was unsure. LPN #2 stated that she immediately went to check Resident #2's NJ Exec O and bathroom and NJ Exec Order 26.4 Resident #2. She then called NJ Exec Order 26.4b1 [redacted]), and all staff members NJ Exec Order 26. the rooms and bathrooms on the unit but could NJ Exec Order 26.4b1. LPN #2 further stated that there was NJ Exec Order 26.4b1 at the time of their search, and that some of the staff members drove down the road where the US FOIA and other staff NJ Exec O Resident #2 on NJ Exec Order 26.4b1]. She stated that Resident #2 was then NJ Exec Order 26.4b1 [redacted] and assessed. LPN #2 confirmed that the resident was at risk for NJ Exec Order 26.4b and had a NJ Exec Order 26.4b1 which was checked every shift for placement and function. When asked if she checked Resident #2's NJ Exec Order 26.4b1 during her shift, she replied, she did, it was present at the time	F0689		

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F0689 SS = SQC-J	Continued from page 6 she checked during their 5:00 P.M. medication administration. She further stated the [NJ Exec Order 26.4b1] went off if residents who had a [NJ Exec Order 26.4b1] attempted to [NJ Exec Order 26.4b1], and that staff must respond and [NJ Exec Order 26.4b1]. When asked if she knew how Resident #2 [NJ Exec Order] she replied if a resident with a [NJ Exec Order 26.4b1] went on the elevator, the [NJ Exec Order 26.4b1], and the elevator would not go down or close. LPN #2 further stated that on [NJ Exec Order 26.4b1], the day the resident [NJ Exec Order] none of that happened; [NJ Exec Order 26.4b1]. On 08/19/2025 at 12:35 P.M., during an interview with the [US FOIA (b)(6)], he stated that maintenance did daily testing on the [NJ Exec Order 26.4b1]) to ensure it was functioning. He stated that all testing for the [NJ Exec Order 26.4b1] was conducted on the morning of [NJ Exec Order 26.4b1], and was functional. On 08/19/2025 at 1:23 P.M., during a telephone interview with the surveyor, the Certified Nursing Assistant (CNA #1) assigned to Resident #2, stated that he [NJ Exec Order 2] Resident #2 after he picked up their dinner tray from their room around 6:00 P.M. on [NJ Exec Order 26.4b] CNA #1 stated that a few minutes later, he heard a [NJ Exec O] called and they all started to [NJ Exec Orde] for the resident. CNA #1 further stated that they [NJ Exec Order 26.] rooms, bathrooms and everywhere and [NJ Exec Order 26.4b1] Resident #2. According to CNA #1, if the resident had a [NJ Exec Order 26.4b1] once they entered the elevator, it triggered the [NJ Exec Order 26.4b1], and they must respond. CNA #1 stated that on the day the resident [NJ Exec Order] there was no [NJ Exec Order 26.4b1]. When asked if he observed Resident #2 [NJ Exec Order 26.4b1], CNA #1 replied, "no, I did not see the resident [NJ Exec Or] neither did I hear any [NJ Exec Order 26.4b1]." On 08/19/2025 at 1:44 P.M., during an interview with LPN #1, she stated that she received a phone call from the nurse on the [NJ Exec Order 26.] who stated that a CNA (CNA #2), who was returning from their break, [NJ Exec Order 26.4b1] LPN #1 stated that she immediately checked Resident #2's room and bathroom, and the resident [NJ Exec Order 26.4b1]. LPN #1 noticed the resident's wheelchair was [NJ Exec Order 2] but their [NJ Exec Order 26.4b1]. A [NJ Exec Order 26.4b1] was activated. LPN #1 further stated that while they were [NJ Exec Order 26.4] for the resident, she received a phone call that the [US FOIA] and another staff member that they had [NJ Exec Order] Resident #2 at the [NJ Exec Order 26.4b1]], [NJ Exe] LPN #1 stated that she went to the [NJ Exec Order] to get the resident and that she noticed the resident had their [NJ Exec Order 26.4b1] on their [NJ Exec Or]	F0689		

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F0689 SS = SQC-J	Continued from page 7 LPN #1 stated the expectations was that if a resident had a NJ Exec Order 26.4b1 and tried to NJ Exec Or the elevator should NJ Exec Orde and all other NJ Exec Orde should be NJ Exec Order 26 for the safety of the resident. When asked if the NJ Exec Or sounded on the day Resident #2 NJ Exec Order she replied, "no, I did not hear the NJ Exec Or or elevator NJ Exec Order 26 that day. Even though I was in the back hall, I should hear the NJ Exec Order 26.4b1." LPN #1 stated that if a resident with a NJ Exec Order 26.4b1, they would be at risk for harm, injury, or death and that Resident #2 could have gotten NJ Exec Order 26.4b1. On 08/19/2025 at 2:49 P.M., during an interview with the US FOIA (b) in the presence of the US FOIA (b)(6) confirmed that on NJ Exec Order 26.4b1, a CNA (CNA #2) returning from their break at approximately 6:22P.M., observed someone who looked NJ Exec Order 26.4b1. CNA #2 notified NJ Ex nurse, who called the NJ Exec Order 26.4b1 nurse, who called NJ Exec Order 26.4b1, initiated a NJ Exec Orde and notified her. The US FOIA stated that she was with Resident #2 at 6:32 P.M., and they NJ Exec Order 2 the resident to the building around 6:49P.M., and assessed the resident. The US FOIA stated that the US FOIA (b)(6) noticed Resident #2, whom she thought was visitor, NJ Exec O the facility through the NJ Exec Order 26.4b1. The US FOIA stated that they observed the resident on a screenshot camera footage NJ Exec Order 26.4b1 6:01 P.M. The US FOIA confirmed she observed the NJ Exec Order 26.4b1 on the resident's NJ Exec Order 26.4b1. The US FOIA further stated that it was important for a resident at risk for NJ Exec Order 26.4b to have a NJ Exec Order 26.4b1 in place for their safety, and that the NJ Exec Order 26.4b1 and placement was checked every shift. The expectation was that if a resident had a NJ Exec Order 26.4b1, our system should be NJ Exec Order 26 if the resident attempted to NJ Exec Orde She further stated there were binders at each nurse's station and at the front desk with pictures and names of residents at risk for NJ Exec Order 26.4b1 The surveyor interviewed the US FOIA (b) on 08/19/2025 at 2:49 P.M. The US FOIA (b) stated that the maintenance staff checked the NJ Exec Or system daily to ensure it was functional. The US FOIA (b) added that it was important to ensure the system was functioning and the NJ Exec Orde will sound to alert staff to residents at risk for NJ Exec Order 26.4b1 When asked if the system was triggered when Resident #2 NJ Exec Order he stated they did not know if the system was triggered for Resident #2. The US FOIA (b) stated that the expectation was that the system should trigger and alert staff if a resident with a NJ Exec Order 26.4b1. The facility was unsure how Resident #2 NJ Exec Order 26.4b1 since all the NJ Exec Order 2 were functioning on the day	F0689		

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BERLIN REHABILITATION AND HEALTHCARE CENTER	100 LONG-A-COMING LANE , BERLIN, New Jersey, 08009

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F0689 SS = SQC-J	Continued from page 8 Resident #2 NJ Exec Order The US FOIA (b) did not provide any other information as to how Resident #2 NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 with their NJ Exec Order 26.4b1 at approximately 6:01 P.M. The US FOIA (b) stated they did not know how Resident #2 NJ Exec Order 26.4b1 and then to the NJ Exec Order 26.4b1. They only had video footage of the resident NJ Exec Order 26.4b1. The US FOIA (b) in the presence of the US FOIA both agreed that if a resident at risk for NJ Exec Order 26.4b NJ Exec the building NJ Exec Order 26.4b1 there could be a potential for harm, injury, or death to the resident. The facility submitted an acceptable Removal Plan (RP) on 08/21/2025 at 12:00 P.M., indicating the actions the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: the facility NJ Exec Order the resident and immediately NJ Exec Order 26.4b1. Resident #2 was placed on NJ Exec Order 26.4b1 their care plan was revised; and the functioning of their NJ Exec Order 26.4b1 was verified. The facility completed a head count to verify all residents were accounted for; conducted a house sweep using an 'NJ Exec Order 26.4b1 to check other residents for NJ Exec Order 26.4b risk; educated all staff on interventions to prevent NJ Exec Order 26.4b1 and verified all binders that identified residents at risk for NJ Exec Order 26.4b were accurate and placed at the nurses' stations and the front desk. The NJ Exec Order 26.4b1 was reviewed, and the US FOIA (b)(6) and off-shift staff were educated on the process for incoming and departing visitors. The Regional Plant Operations inspected doors and NJ Exec Order 26.4b1 functionality; the door lock system was reviewed, and the timer was adjusted; adjustment was made to the frequency/sensitivity for the NJ Exec Order; and the front door system was switched to alert the front door's operator with a push/release mode only. The facility self-corrected the deficient practice, and it was determined that the IJ was PNC. The facility corrected their non-compliance on 08/17/2025. The surveyor verified the implementation of the Removal Plan on-site on 08/25/2025. NJAC 8:39-27.1 (a)	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 156001	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S0000	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.	S0000		09/10/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Complaint #: 2592172 Based on review of facility documents on 08/19/2025, it was determined that the facility failed to ensure staffing ratios were met for 13 of 14-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	S0560	1. No residents were affected by not meeting the State of New Jersey minimum staffing requirements. 2. All residents could have the potential to be affected by this area of concern. 3. Recruitment efforts include: a. Staff Accountability for time and attendance. b. Culture Committee to promote and improve staff morale c. Recruitment Bonuses and Vacant Shift Bonuses d. Job Fairs as needed e. Weekend Shift differential program (Baylor) f. Flexible Orientation Program g. Prize Raffles for staff picking up extra shifts	09/15/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 156001	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/25/2025

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S0560	Continued from page 1 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 AAS-11 staffing, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: On 08/03/25 had 13 CNAs for 119 residents on the day shift, required at least 15 CNAs. On 08/04/25 had 9 CNAs for 119 residents on the day shift, required at least 15 CNAs. On 08/05/25 had 13 CNAs for 119 residents on the day shift, required at least 15 CNAs. On 08/06/25 had 13 CNAs for 119 residents on the day shift, required at least 15 CNAs. On 08/07/25 had 14 CNAs for 119 residents on the day shift, required at least 15 CNAs. On 08/08/25 had 14 CNAs for 119 residents on the day shift, required at least 15 CNAs. On 08/09/25 had 11 CNAs for 124 residents on the day shift, required at least 15 CNAs. On 08/10/25 had 10 CNAs for 120 residents on the day shift, required at least 15 CNAs. On 08/11/25 had 13 CNAs for 119 residents on the day shift, required at least 15 CNAs. On 08/12/25 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. On 08/13/25 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. On 08/14/25 had 12 CNAs for 115 residents on the day shift, required at least 14 CNAs. On 08/15/25 had 11 CNAs for 115 residents on the day shift, required at least 14 CNAs.	S0560	Continued from page 1 h. Flexible scheduling. i. Daily interviews being conducted for walk in applicants j. Daily Staffing Meetings / twice weekly Labor Meetings 4. Staffing Coordinator will audit schedule weekly to monitor compliance with minimum staffing requirements. The Scheduling coordinator will report results of audits to monthly QAPI to identify trends and additional areas of opportunity.	