STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315507	A. BUILDING _____ B. WING _____	02/24/2023

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BARNERT SUBACUTE REHABILITATION CENTER, LLC	**680 BROADWAY SUITE 301 PATERSON, NJ 07514**

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F 000	INITIAL COMMENTS Standard Survey: 2/24/2023 Census: 58 Sample Size: 15 + 3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 623 SS=D	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 discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 623		3/24/23

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

Electronically Signed | 03/16/2023

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 623	Continued From page 1 (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 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for	F 623		

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F 623	Continued From page 2 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: Based on observation, interview and record review, it was determined that the facility failed to notify the resident's representative in writing for an Ex.Order 26.4(b)(1) [redacted]. This deficient practice was identified for 1 of 1 resident, Resident #60 reviewed for Ex.Order 26.4(b)(1)	F 623	1. (a) Resident #60 and the resident's representative(s) were immediately notified in writing and in a language and manner they understand upon Ex.Order 26.4 [redacted] (b)No resident were affected with this deficient practice.	

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F 623	Continued From page 3 The deficient practice was evidenced by the following: On 2/21/23 at 11:50 AM, the surveyor reviewed the hybrid medical records (paper and electronic) of Resident #60. The nurse progress notes revealed that the resident was Ex.Order 26.4(b)(1) to the Ex.Order 26.4(b)(1) on Ex.Order 26.4(b) at 2:45PM. According to the Discharge Minimum Data Set, an assessment tool used to facilitate the management of care dated 1/25/23, reflected that Resident #60 was Ex.Order 26.4(b)(1) with a return not anticipated to the facility. On 2/22/23 at 12:07 PM, the surveyor interviewed the facility's Social Services Director who provided a documentation indicating that the Long-Term Care Ombudsman was notified. However, the resident's responsible party was not provided with a written notification of the reason for an Ex.Order 26.4(b)(1) A review of the facility's policy titled, "Making an Ex.Order 26.4(b)(1) or Discharge" with a review date on 6/2022. 1.) Should it become necessary to make an Ex.Order 26.4(b)(1) or discharge to a Ex.Order 26.4(b)(1) or other related institution, our facility will implement the following procedure ... ... e. Notify the representative (sponsor) or other family member." On 2/22/23 at 12:45 PM, the survey team met with the facility's Licensed Nursing Home Administrator, Director of Nursing, Regional Nurse and Infection Preventionist. The above concern was discussed. There was no further information provided.	F 623	2. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). 3. (a)All resident and resident's representative will be notified in writing of the reason for Ex.Order 26.4(b)(1) and date of transfer or discharge to Ex.Order 26.4(b)(1) or other related institution and mailed out to address obtain from resident record. (b) Social service director was re in-serviced regarding Notice and Transfer or discharge and the resident representative must be notified for the reasons for the move in writing and in the language and manner they understand. The facility must send a copy of the notice to the representative of the Office of the State Long-Term Care Ombudsman at least 30 days before the resident is transferred or discharged. (c) The Director of Social Services or designee will review and audit all Ex.Order 26.4 transfers weekly for 4 weeks and monthly for 3 months to ensure that all written notifications of the reason for an Ex.Order 26.4(b)(1) are sent out certified and received by resident and resident's representative (sponsor) 4. The results of these audits will be discussed in the morning meeting for immediate resolution and will be submitted to the Quarterly Assurance Performance Improvement Committee (QAPI) for review. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for tow consecutive months.	

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F 623	Continued From page 4 NJAC 8:39-5.3; 5.4	F 623		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain professional standards of practice to hold a medication used to treat Ex Order 26. 4B1 [redacted] in accordance with the physician's order (PO) for 2 of 2 residents reviewed, Resident #50 and Resident #59. The deficient practice is evidenced by the following: Reference: New Jersey Statuses Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwised legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states:	F 658	1. Resident #50 and Resident #59.Resident # 50 and #59 was assessed and their Ex Order 26. 4B1 parameters was addressed with all licensed nursing staff. No residents were affected with this deficient practice. 2. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). 3. (a) Licensed nursing staff was in-serviced regarding the policy and procedure on Administration of Medication by checking medication cautionary on medication parameters. (b) The Director of Nursing or designee will audit daily Ex Order 26. 4B1 medications with parameters for compliance of medication administration. Interventions including immediate education provided if nurse found not following MD education with staff and as needed. (c) Director of Nursing or designee will audit 5 charts weekly for 4 weeks and monthly for 3 months thereafter for medication parameters. (d) Audits will be monitored for completion	3/24/23

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F 658	Continued From page 5 "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 2/15/23 at 11:35 AM, the surveyor observed Resident #50 in bed in his/her room. The surveyor reviewed Resident #50's hybrid medical records that revealed the following: The Admission Record (an admission summary) revealed that Resident #50 was admitted to the facility with a diagnosis that included but not limited to Ex Order 26. 4B1 . The Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of 1/23/23, revealed a Brief Interview of Mental Status (BIMS) score of [redacted] out of 15, which indicated that the resident was Ex Order 26. 4B1 . The January and February 2023 electronic Medication Administration Record (eMAR) included a physician's order for Ex Order 26. 4B1 tablet- Give 1 tablet by mouth two times a day for Ex Order 26. 4B1 with a start date of 1/19/23. The medication had instructions to obtain Ex Order 26. 4B1 ([redacted]) and to hold the medication if the Ex Order 26. 4B1 ([redacted]) Ex Order 26. 4B1 was	F 658	by the Administrator and will be discussed in the morning clinical meeting. Interdisciplinary Team will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. 4. Results on this Audits will be discussed in clinical morning meeting for immediate resolution. This will be included in monthly Quality Assurance Performance Improvement and this will a part of quarterly QA program.	

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F 658	Continued From page 6	F 658		

less than Ex.Order 26.4(b)(1) and Ex Order 26. 4B1 Ex.Order 26.4(b)(1)) less than Ex.Order 26.4(b)(1)
A review of the documentation on the eMAR revealed that the medication Ex Order 26. 4B1 was administered once in January 2023 and 4 times in February 2023 when the medication should have been held due to Ex.Order 26.4(b)(1).

On 2/22/23 at 11:13 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) and discussed the above concern. LPN #1 acknowledged that the Ex.Order 26.4(b)(1) was administered and should have been held due to Ex.Order 26.4(b)(1). LPN #1 stated, "the nurses should ensure that they check three times prior to administering the Ex Order 26. 4B1 medication and to make sure the Ex Order 26. 4B1 and heart rate are not outside the parameters."

2. On 2/22/23 at 9:53AM, the surveyor reviewed the hybrid medical records for Resident #59. The resident was admitted to the facility on Ex Order 26. 4B1 and Ex.Order 26.4(b)(1) in the facility on Ex Order 26. 4B1.

A review of the electronic Order Summary Report for December 2022 reflected a PO dated 7/1/22 for a medication, Ex Order 26. 4B1 tablet. The PO specified to give Ex tablet Ex Order 26. 4B1 by mouth one time a day for Ex Order 26. 4B1 and to hold the medication for Ex.Order 26.4(b)(1). Further review of the electronic PO reflected an order dated 6/15/22 for a medication, Ex Order 26. 4B1 tablet. The PO specified to give Ex tablet Ex Order 26. 4B1 by mouth two times a day for Ex Order 26. 4B1 and to hold the medication for a Ex.Order 26.4(b)(1) and Ex.Order 26.4(b)(1).

A review of the eMAR for September 2022 through November 2022 reflected that the

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F 658	Continued From page 7 medication Ex Order 26. 4B1 was to be administered at 0900 (9AM). The eMAR reflected that the Ex Order 26. 4B1 was signed as given when the resident's Ex.Order 26.4(b)(1). Further review of the documentation on the eMAR revealed that the medication was administered 2 times in September 2022, 3 times in October 2022, and 7 times in November 2022. A review of the eMAR for September 2022 through November 2022 reflected that the medication Ex Order 26. 4B1 was to be administered at 0830 (8:30AM and 1630 (4:30PM). The eMAR reflected that the Ex Order 26. 4B1 was signed as given when the resident's Ex.Order 26.4(b)(1) and h Ex.Order 26.4(b)(1) Further review of the documentation in the eMAR revealed that the medication was administered 3 times in September 2022, 12 times in October 2022, and 9 times in November 2022. A review of the facility policy titled, "Administering Medications Using Electronic System (PCC)", with a revised date of 2/3/23 under Policy Statement, "Medications shall be administered in a safe and timely manner, and as prescribed." A further review of the policy under Policy Interpretation and Implementation indicated, "3. Medications must be administered in accordance with doctor's orders, including any required time frame and following medication cautionary. 7. The following information must be check/verified for each resident prior to administering medication: ...b. Vital signs, if necessary." On 2/22/23 at 12:49 PM, the team met with the Licensed Nursing Home Administrator (LNHA), Regional Nurse, Director of Nursing (DON), and	F 658		

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F 658	Continued From page 8 Infection Preventionist (IP). The surveyor discussed the above concern. The DON acknowledged that the blood pressure medications should have been held as indicated in the PO.	F 658		
F 812 SS=D	NJAC 8:39- 29.2 (d) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of documentation provided by the facility, it was determined that the facility failed to maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development of	F 812	1. All kitchen equipment identified (fan, wire racks, dual stack standing oven, small shelf- and top of the steamer were immediately cleaned and sanitized. No residents were affected with this deficient practice.	3/24/23

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F 812	Continued From page 9 a food borne illness. This deficient practice was observed and evidenced by the following: On 2/15/23 at 10:00 AM, during the initial tour of the kitchen in the presence of the Food Service Director (FSD), the surveyor observed the following: At 10:20 AM, in the presence of the FSD, the surveyor observed the following in the walk-in refrigerator: 1. One fan covered with a heavy build up of a gray fuzzy substance. The FSD identified the substance as "dust build up" and acknowledged that the substance could dislodge from "air blowing and go onto the food." 2. On all the wire racks in the refrigerator (five racks with four shelves each), the surveyor observed a sticky brown and black debris (which could be wiped off with a paper towel). The FSD was unable to identify the substances. The surveyor further observed the following during the kitchen tour in the presence of the FSD: 3. The dual stack standing oven had a white chalk-like substance on the side of the top oven doors and a gray dust like substance on the top on the oven. The substance was able to be wiped off with a paper towel. The FSD was unable to identify the substance. 4. A small shelf connected to the back of the six-range stove top had a heavy buildup of a sticky green colored substance. The FSD described it as "grease". The substance was able	F 812	2. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future) 3. (a) Food Service Director (FSD) reviewed and in-service all kitchen staff on Cleaning and Sanitation of Equipment under Policy, Cleaning and sanitation of equipment is to remove food debris that bacteria need to grow, and to kill those bacteria that are present to prevent contamination from foreign substances and potential for the development of food borne illness. Kitchen staff were also in-service on Policy under Procedure indicated Cleaning and Sanitation frequency of cleaning equipment. (b)Regional Food Service Director re in serviced Dietary staff regarding sanitation and Cleaning of Equipment. (c)Food Service Director or designee will do a daily audit for 4 weeks and weekly audit for 3 months for kitchen cleaning and sanitation of all kitchen equipment to make sure that no substances and potential for the development of a food borne illness. 4. Audits will be brought to and discussed during our monthly Quarterly Assurance Performance Improvement Committee (QAPI) meeting for review and determined if changes are need.	

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F 812	Continued From page 10	F 812		

to be partially wiped off with a paper towel.

5. The top of the steamer was observed with a heavy build-up of a brown and black-colored caked on substance. The substance was not able to be wiped off with a paper towel. The FSD was unable to identify the substance.

On 2/15/23 at 10:50 AM, the FSD stated, "the walk-in refrigerator should be cleaned weekly and all the other equipments should be cleaned daily at the end of the evening shift." The FSD provided the surveyor with a copy of the daily cleaning schedule which revealed that from 2/1/23 through 2/15/23 the kitchen shelves were being checked off as cleaned. The FSD could not speak to the accountability of cleaning the walk-in refrigerator and other kitchen equipment.

A review of the facility policy titled, "Cleaning and Sanitation of Equipment" with a revised dated of 9/13/2022 revealed under Policy, "Cleaning and sanitation of equipment is to remove food debris that bacteria need to grow, and to kill those bacteria that are present. It is important that the cleaned and sanitized equipment are stored dry so as to prevent bacteria growth." A further review of the policy under Procedure indicated "Cleaning and Sanitation:

1. Refrigerator - Walk-In.
Shelving.
Frequency: Weekly.
a. Remove all food shelves
b. Scrub shelves with sanitizing solution and clean cloth. DO NOT USE ABRASIVES.
c. Wash walls with sanitizing solution and clean cloth.
d. Allow air dry.

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F 812	Continued From page 11 e. Return food to shelves. 2. Oven - Convection - Frequency: Immediate. a. Remove spills, spillovers, and burned food deposits. Frequency: Daily a. Wipe cool over exterior and interior with wet cloth. b. Remove and scrape drip pans, send through dishwasher cycle, and allow air dry. Frequency: Weekly a. Wipe and clean oven exterior. Use damp cloth." On 2/17/23 at 12:45 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing and discussed the above concerns during the initial kitchen tour. The LNHA acknowleged with the findings above. No further information was provided. NJAC 8:39-17.2(g)	F 812		

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
	16008	A. BUILDING: _____ B. WING _____	02/24/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following. Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General	S 560	1. All efforts to hire facility Certified Nursing Aide(s) C.N.A will continue until there is adequate staff to serve all residents. Until the time, facility will utilize staffing agencies to fill any open spots in the schedule. Contracts with additional staffing agencies will be secured to supplement facility staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to become more competitive	3/24/23

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

Electronically Signed | 03/16/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16008	A. BUILDING: _____ B. WING _____	02/24/2023

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

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S 560	Continued From page 1 Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.	S 560	in the marketplace and surrounding area. In addition, daily and weekly meetings with the staffing coordinator. No resident was affected with this deficient practice. 2. All residents have the potential to be affected by this deficient practice. Therefore, this applies to all residents (current and future). 3. Contracts with additional staffing agencies will be secured to supplement facility staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to become more competitive in the marketplace and surrounding area. In addition, daily and weekly meetings with the staffing coordinator The Administrator or designee will review staffing schedules weekly for 4 weeks and monthly for 3 months to ensure adequate staffing for all shifts. 4. The results of these reviews will be submitted to the (Quarterly Assurance Performance Improvement (QAPI) committee for review. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting/review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16008	A. BUILDING: _____ B. WING _____	02/24/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 2-week period beginning 1/29/23 to 2/4/23 and ending 2/5/23 to 2/11/23 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements in CNAs to total staff on 6 of 14 day shifts as follows: -01/29/23 had 6 CNAs for 59 residents on the day shift, required 7 CNAs. -02/04/23 had 7 CNAs for 61 residents on the day shift, required 8 CNAs. -02/05/23 had 6 CNAs for 61 residents on the day shift, required 8 CNAs. -02/07/23 had 7 CNAs for 61 residents on the day shift, required 8 CNAs. -02/09/23 had 7 CNAs for 61 residents on the day shift, required 8 CNAs. -02/10/23 had 7 CNAs for 61 residents on the day shift, required 8 CNAs. The facility's Licensed Nursing Home Administrator and Director of Nursing,was informed of their deficient practice on 2/17/23 at 12:45 PM.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315507 Y1	A. Building B. Wing Y2	3/30/2023 Y3

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

This report is completed by a 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 03/24/2023	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 03/24/2023	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 03/24/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
2/24/2023	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
16008	A. Building B. Wing	3/30/2023

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/24/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 2/24/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: M4VW12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315507	A. BUILDING **01** B. WING _____	**02/24/2023**

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

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 02/21/23. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 02/21/23 and was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Barnert Subacute Rehabilitation Center is located on the third floor within a six story building. It was built in 1966 with an addition built in 1986. It is composed of Type II protected construction. The facility is divided into six smoke zones. The generator does approximately 40% of the building as per the Regional Maintenance Director. The current occupied beds are 57 of 68.	K 000		

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

Electronically Signed | 03/09/2023

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.