

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 030307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/23/2021
NAME OF PROVIDER OR SUPPLIER WILEY MISSION		STREET ADDRESS, CITY, STATE, ZIP CODE 99 EAST MAIN STREET MARLTON, NJ 08053		
(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 interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 1 out of 42 shifts reviewed. 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	S 560	S560 The following corrective actions have been implemented. S560 Mandatory Access to Care 8:39-5.1(a) 1. How the corrective action will be accomplished for those residents found to be affected by the deficient practice. The Director of Nursing and Charge nurse will review the schedule	12/21/21

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

TITLE

(X6) DATE

Electronically Signed

12/10/21

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S 560	<p>Continued From page 1</p> <p>nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at 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:</p> <p>One Certified Nurse Aide (CNA) to every eight residents for the day shift.</p> <p>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 CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and</p> <p>One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.</p> <p>On 11/15/21 at 10:01 AM, the Licensed Nursing Home Administrator (LNHA) informed the surveyor during entrance conference, that the facility had decreased their number of residents at the facility in regard to staffing shortages. The LNHA stated that the facility tried to obtain coverage for any staff callouts. The LNHA stated that the facility did not use agency contracted CNAs, that the facility used their own staff for CNA callouts.</p> <p>As per the "Nurse Staffing Report" completed by the facility for the weeks of 10/31/21 to 11/6/21 and 11/7/21 to 11/13/21, the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below:</p>	S 560	<p>weekly to ensure the required minimum direct care staff to resident ratios are maintained.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected by the deficient practice if direct care staff to resident ratios are not maintained.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.</p> <p>The Director of Nursing or Charge nurse is to be notified when a CNA who calls out is unable to be replaced.</p> <p>A flyer was posted at timeclock and where staff schedule is located instructing CNA's on bonus opportunities for picking up extra shifts when facility does not meet minimum staffing requirements.</p> <p>Incentive bonuses will continue to be offered to CNAs for picking up extra shifts.</p> <p>4. How the facility will monitor its</p>	

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S 560	Continued From page 2 11/13/21 had 4 CNAs for 39 residents on the day shift, required 5 CNAs. NJAC 8:39-5.1(a)	S 560	<p>corrective actions to ensure that the deficient practice is being corrected and will not recur.</p> <p>The Director of Nursing and the charge nurse will review the CNA schedule weekly and 24 hours prior to the assigned day to ensure the required minimum direct care staff to resident ratios are maintained.</p> <p>The Quality Assurance committee will meet quarterly to review and discuss compliance for staffing.</p>	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 030307	MULTIPLE CONSTRUCTION A. Building B. Wing Y1	DATE OF REVISIT Y2 1/11/2022 Y3
NAME OF FACILITY WILEY MISSION		STREET ADDRESS, CITY, STATE, ZIP CODE 99 EAST MAIN STREET MARLTON, NJ 08053

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
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 12/21/2021	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed LSC _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed LSC _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed LSC _____
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REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	
FOLLOWUP TO SURVEY COMPLETED ON 11/23/2021		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		