STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING _____ B. WING _____	C 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT ABSECON	**1020 PITNEY ROAD ABSECON, NJ 08201**

(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 #: NJ00166465 Census: 148 Sample Size: 5 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 SURVEY.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Complaint #: NJ00166465 Based on observation, interviews, review of the medical record, and other pertinent facility documentation on , , it was determined that the facility failed to consistently document Activities of Daily Living (ADL) care as being provided in the "Documentation Survey Report (DSR)" resident's Activities of Daily Living (ADL) status and follow the facility policy for "ADL Documentation." This deficient practice was evidenced for 2 of 2 residents (Residents #4 and #3) reviewed for ADL care. This deficient practice was evidenced by the following:	F 677	Element #1 Residents identified were immediately assessed and no adverse reaction was found Certified Nurses Aides (CNA) that were involved with the cited deficient practice were counselled and re-educated to ensure that residents who receive assistance with activities of daily living have daily consistent documentation of the services provided. Element # 2. All Residents who require activities of daily living assistance have the potential to be affected by the cited deficient practice.	9/18/23

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

Electronically Signed | 09/06/2023

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 677	Continued From page 1 On 08/16/23 at 12:23 PM, the surveyor observed Resident #4 in bed and checked the resident for NJ Ex.Order 26.4(b)(1) with the Licensed Practical Nurse/Unit Manager (LPN/UM) and CNA #2. The surveyor reviewed the medical record for Resident #4: The Admission Record revealed that Resident #4 was admitted to the facility on [redacted] and was readmitted on [redacted] with medical diagnoses which included but were not limited to [redacted] The quarterly MDS dated [redacted] indicated that Resident #4 had a BIMS score of [redacted] out of a possible [redacted] which indicated [redacted] The MDS also indicated the resident needed assistance or was totally dependent on staff for ADL tasks including NJ Ex.Order 26.4(b)(1) [redacted]. The "ADL self care deficit" care plan dated NJ Ex.Order 26.4(b)(1) indicated an intervention, "Assist of one to two people with ADLs [...]." Review of Resident #4's DSR (ADL Record) and the progress notes (PN) for the month of NJ Ex.Order 26.4(b) and NJ Ex.Order 26.4(b) showed no documented evidence that the tasks were completed for NJ Ex.Order 26.4(b)(1) [redacted] were provided and/or the resident refused care on the following dates and shifts:	F 677	Element #3 a) Certified Nurses Aides (CNA) and nurses were re-in-serviced regarding facility□s activities of daily living Policy and Procedures to ensure that residents who requires activities of daily living have consistent documentation of the services provided. This in-service will be given annually, during orientation for newly hired Certified Nurses Aides (CNA) licensed nurses, and when deemed necessary. b) The Unit manager and or designee will check daily compliance with completion of activities of daily living documentation. Any non-compliance with the completion of documentation will be immediately corrected and/or disciplinary action taken for non-compliance. Outcomes will be reported to the Director of Nursing (DON)/Assistant Director of Nursing (ADON) or the designee. Element #4 a. Assistant Director of Nursing (ADON) and or designee will perform twice weekly audits of 10 residents x 4 weeks and then bi-weekly x 3 months to ensure that residents activities of daily living documentation is completed. Any negative results will be corrected through re-education and or disciplinary actions as appropriate by the Assistant Director of Nursing (ADON) or the Director of Nursing (DON). b. Results of the audits will be submitted to the Quality Assessment and Assurance (QAA) committee who meets quarterly for	

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F 677	Continued From page 2 On the 7:00 AM - 3:00 PM shift on [NJ Ex.Order 26.4(b)(1)] and NJ Ex.Order 26.4(b)(1) On the 3:00 PM - 11:00 PM shift on [NJ Ex.Order 26.4(b)(1)] and NJ Ex.Order 26.4(b)(1). On the 11:00 PM -7:00 AM shift on [NJ Ex.Order 26.4(b)(1)] and 0[NJ Ex.Order 26.4(b)]. 3. On 08/16/23 at 1:03 PM, the surveyor observed Resident #3 in bed and performed [redacted] checks on the resident with the LPN/UM. The surveyor reviewed the medical record for Resident #3: According to the Admission Record, Resident #3 was admitted to the facility on [redacted] and was readmitted to the facility on [redacted] with medical diagnoses which included but were not limited to [redacted] The quarterly MDS dated [NJ Exec. Order 26:4.b.1] indicated that Resident #3 had a BIMS score of [redacted] out of a possible [redacted] which indicated that the resident was [redacted] The MDS also revealed that the resident required extensive assistance with ADL tasks including [NJ Ex.Order 26.4(b)(1)] [redacted]. The care plan dated [redacted] indicated,	F 677	review and to determine the frequency and necessity of future audits and actions taken.	

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F 677	Continued From page 3 "[Resident #3] requires assistance with ADL functions." Review of Resident #3's DSR and the PN for the month of [NJ Ex.Order 26.4] and [NJ Ex.Order 26.4(b)] showed no documented evidence that the tasks were completed for NJ Ex.Order 26.4(b)(1) were provided and/or the resident refused care on the following dates and shifts: On the 7:00 AM - 3:00 PM shift on [NJ Ex.Order 26.4(b)(1)], and NJ Ex.Order 26.4(b)(1) On the 3:00 PM - 11:00 PM shift on [NJ Ex.Order 26.4(b)(1)], and NJ Ex.Order 26.4(b)(1). On the 11:00 PM -7:00 AM shift on [NJ Ex.Order 26.4(b)(1)] and [NJ Ex.Order 26.4(b)(1)]. During an interview with the surveyor on 08/16/23 at 1:47 PM, LPN #3 stated that the CNAs are able to provide ADL care to all of the residents on their assignments including providing care every two hours. LPN #3 stated that the expectation for the aides was to document the ADL care, "every day, every shift, 100% documentation. " During an interview with the surveyor on 08/16/23 at 2:04 PM, CNA #1 stated that she was able to provide high quality ADL care for all of the residents on her assignment including checking on and changing residents every two	F 677		

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F 677	Continued From page 4 hours. CNA #1 stated that the aides were supposed to document on each resident every shift. During an interview with the surveyor on 08/18/23 at 12:26 PM, the DON stated that she expected that ADLs would be documented on the DSR 100% of the time. The facility policy, "ADL Documentation" dated 12/22 indicated under the "Compliance Guidelines" section, "ADL care will be recorded in the CNA tasks flow sheet and or in the nursing note." NJAC 8:39-27.1 (a) 8:39-35.2(g).	F 677		
F 695 SS=B	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00166465 Based on observation, interview, and review of facility documentation on 08/16/23 and 08/18/23 it was determined that the facility failed to obtain a physician's order for the use of [redacted] and failed to follow their facility's policy for [redacted]	F 695	Element #1 Physician order was immediately obtained for resident #2 for [redacted] Element # 2 All residents receiving oxygen therapy have the potential to be affected by the	9/18/23

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F 695	Continued From page 5 Administration" for 1 of 2 residents (Resident #2) reviewed for [redacted] The deficient practice was evidenced by the following: On 08/16/23 at 12:48 PM, the surveyor observed Resident #2 in bed wearing a [redacted]) which was connected to an [redacted]. The surveyor observed that the [redacted] was set to [redacted]. The surveyor interviewed Resident #2 at this time who stated that she used the [redacted] continuously for [redacted] and that they usually received [redacted] but that they recently had [redacted] and required [redacted] The surveyor reviewed the medical record for Resident #2: The Admission Record indicated that Resident #2 was admitted to the facility on [redacted] and was readmitted on [redacted] with medical diagnoses which included but were not limited to [redacted] The quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted] indicated	F 695	cited deficient practice. Element #3 " License nurses were re- in-serviced on the facility□s policy to obtain and maintain physician order for residents on oxygen therapy. " Nursing admission checklist will be completed by the nursing supervisor/nurse unit manager for new and or re-admit residents to assure that resident who are admitted/re-admitted and are receiving oxygen therapy have the physician order for the oxygen. The completed checklist will be submitted to the Director of Nursing (DON) for review. Element #4 Director of Nursing (DON) and or nurse designee will complete a weekly audit on 10 residents who receieve oxygen x 4 weeks and monthly x 3 months to ensure that residents who receives oxygen therapy have current physician order for oxygen. Negative outcome will be corrected immediately through re-education and or disciplinary actions as appropriate. Results of the audits will be submitted to the Quality Assessment and Assurance (QAA) committee who meets quarterly for review and to determine the frequency and necessity of future audits and actions taken.	

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F 695	Continued From page 6 that Resident #2 had a Brief Interview for Mental Status score of [redacted] out of a possible 15 which indicated that the resident was [redacted] The MDS also indicated that the resident used [redacted] while as a resident. The [redacted] care plan indicated an intervention to, "provide [redacted] as ordered." Review of the Order Summary Report dated [redacted] for Resident #2 failed to reveal a physician's order for [redacted] Review of the August Treatment Administration Record (TAR) for Resident #2 failed to reveal any documentation that the nurses administered [redacted]. During an interview with the surveyor on 08/16/23 at 2:45 PM, the Licensed Practical Nurse (LPN) #1 stated that Resident #2 wore [redacted] continuously but that sometimes they might take it off. LPN #1 stated that residents should have a physician's order if they are on [redacted] LPN #1 continued that maybe when the resident went to the hospital and was readmitted that they forgot to initiate another order for [redacted] During an interview with the surveyor on 08/16/23 at 2:59 PM, the Licensed Practical Nurse/UM (LPN/UM) stated that there was no physician's order for Resident #2's [redacted] The LPN/UM stated that she believed that the resident was hospitalized from [redacted] and that the order was not renewed when the resident was readmitted to the facility. The LPN/UM stated that she was responsible to ensure that the [redacted] had a physician's order but that she had not gotten a chance to check yet. The LPN/UM stated	F 695		

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F 695	Continued From page 7 that the importance of having a physician's order was to ensure that it was being administered and at the right rate. The LPN/UM continued that the TAR was generated from the physician's orders and that because there was no physician order that the nurses could not document that the resident received [redacted] on the TAR. During an interview with the surveyor on 08/18/23 at 12:26 PM, the Director of Nursing (DON) stated that Resident #2 had a physician's order in place for the [redacted] before they went to the hospital. The DON continued that the order was missed and that all residents who used supplemental [redacted] should have physician's orders for [redacted] The facility policy, "Oxygen Administration" with a reviewed date of 02/23 indicated, "Oxygen will be administered as per MD order to aid in breathing. Emergency oxygen may be administered by licensed nurse without an M.D. [medical doctor] order. The M.D. will be consulted as soon as possible and order oxygen if continuation is required." The policy also indicated under the "Procedure" section to "1. Check M.D. Order," "6. Plug into concentrator dial liter flow as per M.D. order," and "9. Document initiation of oxygen in nursing notes including time, flow, indication, and method: cannula or mask and in the TAR (Treatment Administration Record.) Document use and resident reaction to oxygen." NJAC 8:39-29.2(d).	F 695		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842		9/18/23

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F 842	Continued From page 8 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842		

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F 842	Continued From page 9 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00166465 Based on observation, interview, and review of facility documentation on [redacted] and [redacted] it was determined that the facility failed to document in the resident's medical record lifesaving measures when the resident was found [redacted] and follow the facility policies for "Procedure for CPR- Cardiopulmonary Resuscitation" and "Documentation in Medical Record." This deficient practice was evidenced for 1 of 2 residents reviewed for [redacted] (Resident #1).	F 842	Element #1 Licensed practical nurse (LPN) that was involved with the cited deficient practice was counselled and re-educated to ensure that all appropriate documentation is entered in the patient□s medical record in a timely manner. Element # 2. All Residents who require documentation entered into their medical records have the potential to be affected by the cited deficient practice.	

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F 842	Continued From page 10 The deficient practice was evidenced by the following: 1. The surveyor reviewed the closed medical record for Resident #1: Resident #1 was admitted to the facility on [redacted] and was readmitted to the facility on [redacted] with medical diagnoses which included but were not limited to [redacted] The quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted] indicated that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of a possible 15 which indicated [redacted]. The New Jersey Practitioner Orders for Life-Sustaining Treatment dated [redacted] indicated that Resident #1 was a [redacted]" ([redacted]). The Order Summary Report dated [redacted] revealed a [redacted] physician's order for, [redacted] The [redacted] eMAR [electronic Medication Administration Record] Progress Note at 08:24 (8:24 AM) written by Licensed Practical Nurse (LPN) #1 indicated, '[redacted]]." The [redacted] Nursing/Clinical Progress Note at	F 842	Element #3 a) Nurses were re-in-service regarding facility□s documentation policy, to ensure documentation is entered in the medical chart accurately and in a timely manner. This in-service will be given annually, during orientation for newly hired licensed nurses, and when deemed necessary. b) The Unit manager and or designee will check daily compliance with completion of nursing documentation. Any non-compliance with the completion of documentation will be immediately corrected and/or disciplinary action taken for non-compliance. Outcomes will be reported to the Director of Nursing (DON)/Assistant Director of Nursing (ADON) or the designee. Element #4 a. Assistant Director of Nursing (ADON) and or designee will perform weekly audits of 10 medical records x 4 weeks and then bi-weekly x 3 months to ensure that residents documentation is completed. Any negative results will be corrected through re-education and or disciplinary actions as appropriate by the Assistant Director of Nursing or the Director of Nursing. b. Results of the audits will be submitted to the Quality Assessment and Assurance (QAA) committee who meets quarterly for review and to determine the frequency and necessity of future audits and actions taken.	

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F 842	Continued From page 11 14:18 (2:18 PM) written by LPN #1 indicated, NJ Ex.Order 26.4(b)(1) [redacted] in [...]. [Family member] was made aware resident had a [redacted] and [he/she] stated let them take the [redacted]. MD was notified." The [redacted] Nursing/ Clinical Progress Note at 16:49 (4:49 PM) written by the Registered Nurse/Unit Manager (RN/UM) indicated, [redacted] NJ Case ID #[redacted]." Further review of the progress notes failed to reveal any additional progress notes that were dated [redacted]. The progress notes failed to indicate that Resident #1 was found [redacted] that any NJ Ex.Order 26.4(b)(1) were initiated, or that the resident [redacted] During an interview with the surveyor on 08/16/23 at 10:45 AM, LPN #2 stated that they knew and took care of Resident #1 and that they were the resident's nurse on the evening before [redacted]. LPN #2 stated that the evening before Resident #1 [redacted] that an aide fed them dinner, that she gave them their meds, and that they responded as usual. LPN #2 stated that the expectation when a resident who was a [redacted] became [redacted] or [redacted] was that you would call a ' [redacted] LPN #2 continued that they would document, "what happened and what you did" in the nursing progress notes after the [redacted] " ended.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING _____ B. WING _____	C 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT ABSECON	**1020 PITNEY ROAD ABSECON, NJ 08201**

(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 842	Continued From page 12 During an interview with the surveyor on 08/16/23 at 11:35 AM, the Registered Nurse/Unit Manager (RN/UM) stated that she was called to come to the facility on [redacted] because she was the RN who lived closest to the facility. The RN/UM stated that by the time she got to the facility that [redacted] had already been done and that the emergency medical technicians (EMTs) had already came and went. The RN/UM stated that her expectation was that if a resident who was a [redacted] was [redacted] and [redacted] that staff would start [redacted] have someone call [redacted], get the [redacted] (NJ Ex.Order 26.4(b)(1) [redacted]), and have someone start documenting. The RN/UM continued that the nursing staff should [redacted] until the EMTs arrive. The RN/UM stated that the nurse should have written a progress note to indicate what they did after the resident was [redacted]. During an interview with the surveyor on 08/16/23 at 2:04 PM, the Certified Nursing Assistant (CNA) #1 stated that she was assigned to care for Resident #1 on the night that they [redacted] CNA #1 stated that on [redacted] while performing [redacted] e she noticed that Resident #1 was [redacted] but that they were [redacted]. CNA #1 stated that she immediately told LPN #4 and that LPN #3 and LPN #4 went to revive Resident #1. Review of the [redacted] 1" Daily Report for [redacted] indicated for Resident #1, [redacted], [redacted], pt [patient] [redacted] d at [redacted] During an interview with the surveyor on 08/18/23 at 12:36 PM, the DON stated that her expectation was that the nurse would have documented his actions after Resident #1 was [redacted] in a progress note. The DON	F 842		

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	315244	A. BUILDING _____ B. WING _____	C 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT ABSECON	**1020 PITNEY ROAD ABSECON, NJ 08201**

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F 842	Continued From page 13 continued that the importance of documentation was to convey what was done for the resident in the documentation. The facility policy, "Procedure for CPR-Cardiopulmonary Resuscitation" with a reviewed date of 09/22 indicated under the "Procedure" section to "Document all appropriate information [...] in the medical record." The facility policy, "Documentation in Medical Record" with a reviewed date of 01/18/23 indicated under the "Policy Explanation and Compliance Guidelines" section, "Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy." The policy also indicated, "Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred." NJAC 8:39-35.2(d)(6).	F 842		

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
	060115	A. BUILDING: _____ B. WING _____	C 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT ABSECON	1020 PITNEY ROAD ABSECON, NJ 08201

(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 Complaint #: NJ00166465 Census: 148 Sample: 5 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documents on 8/16/23 and 8/18/23, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shift as mandated by the State of New Jersey. The facility was deficient in Certified Nursing Assistants (CNA) staffing for residents on 5 of 14 day shifts. This deficient practice had the potential to affect all residents. Findings include:	S 560	1. There were no care concerns reported on the shifts that were identified. 2. All residents have the potential to be affected by this deficient practice. The Director of Nursing reviewed the last 30 days of the Certified Nurses Aides (CNA) staffing report. The Interdisciplinary Care Team reviewed facility grievance log and care and no care concerns were identified.	9/18/23

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

Electronically Signed — 09/06/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060115	A. BUILDING: _____ B. WING _____	C 08/18/2023

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) COMPLETE DATE
S 560	Continued From page 1 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 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: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) 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 One (1) 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. 1. As per the "Nurse Staffing Report" completed by the facility for the weeks of 07/30/23 through 08/12/23, the staffing-to-resident ratio did not meet the minimum requirements. The facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -07/30/23 had 17 CNAs for 147 residents on the day shift, required at least 18 CNAs. -07/31/23 had 17 CNAs for 147 residents on the day shift, required at least 18 CNAs. -08/05/23 had 15 CNAs for 147 residents on the day shift, required at least 18 CNAs.	S 560	3. Facility Staffing Coordinator was in serviced on 08/18/2023 on the requirements for proper staffing and ratios and the need to review and address the staffing needs daily to meet the state requirements. Recruitment efforts are in place to assist the facility in hiring staff. Certified Nurses Aides (CNA)□s receive sign on bonuses, referral bonuses and tuition aid for Certified Nurses Aides (CNA) classes at times. The facility also has paid advertisements to help with our recruitment effort. The Staffing Coordinator or designee also reviews staff attendance records monthly to ensure that excessive callouts are addressed. 4. The Facility Administrator, Director of Nursing and the Staffing Coordinator will conduct weekly meetings x4 then monthly x 6 to review staffing schedules, upcoming needs, and the efficacy of the systems in place to fill the facility needs. Results of the audits will be submitted to the Quality Assessment and Assurance (QAA) committee who meets quarterly for review and to determine the frequency and necessity of future audits and actions taken.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060115	A. BUILDING: _____ B. WING _____	C 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 2 -08/06/23 had 15 CNAs for 145 residents on the day shift, required at least 18 CNAs. -08/12/23 had 15 CNAs for 146 residents on the day shift, required at least 18 CNAs. During an interview with the surveyor on 08/18/23 at 12:26 PM, the Director of Nursing (DON) stated that she was aware of the staffing regulations. The DON stated that the facility was in a partnership with a LPN school to recruit new staff, that they offered referral bonuses for nurses, and that they were paying for people to take the classes necessary to become CNAs.	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
315244 Y1	A. Building B. Wing Y2	9/27/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT ABSECON	1020 PITNEY ROAD ABSECON, NJ 08201

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 F0677	Correction	ID Prefix F0695	Correction	ID Prefix F0842	Correction
Reg. # 483.24(a)(2)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed
LSC	09/18/2023	LSC	09/18/2023	LSC	09/18/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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?
8/18/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060115 Y1	A. Building B. Wing Y2	9/27/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT ABSECON	1020 PITNEY ROAD ABSECON, NJ 08201

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/18/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
8/18/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO