STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315260	A. BUILDING _____ B. WING _____	C 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	600 PEMBERTON BROWN MILLS RD PEMBERTON, NJ 08068

(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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS C/O # NJ 162474, 163363, 166868, 167305, 169221, 170293, 171693, 172029, 173422, 174422 Standard Survey 06/20/2024 Census: 191 Sample Size: 35+3 closed records The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
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, review of the medical record and review of other facility records, it was determined that the facility failed to follow a physician's order for a NJ Ex Order 26.4(b)(1) to rule out a NJ Ex Order 26.4(b)(1)). This deficient practice was identified for 1 of 2 resident's (Resident #43) reviewed for NJ Ex Order 26.4(b)(1). This deficient practice was observed by the following:	F 658	I. An interview was conducted with Resident #43 on 6/18/24 and NJ Ex O denied any NJ Ex Order 26 symptoms. Follow-up was conducted with the Physician□s Assistant to inquire about the order for NJ Ex Order 26.4(b) to NJ Ex Order 26.4(b)(1) who reported that the order was written in error. PA discontinued order for NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1).	7/26/24

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

Electronically Signed | 07/02/2024

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F 658	Continued From page 1 Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; 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." Reference: New Jersey Statutes Annotated Title 45. Chapter 11. New Jersey Board of Nursing Statutes 45:11-23. Definitions " b. The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such 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 prescribe by a licensed or otherwise legally authorized physician or dentist. Diagnosing in the context of nursing practice means that identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen. Such diagnostic privilege is distinct from a medical diagnosis. Treating means selection and performance of those therapeutic measures essential to the effective management and execution of the nursing regimen. Human response means those signs, symptoms and processes which denote the individual's health need or reaction to an actual or potential health	F 658	II. All residents in the facility have the potential to be affected by this deficient practice. III.Audits were conducted facility-wide for all residents to ensure there are no other orders entered as standard other that should have been mapped to MAR/TAR for follow-up. A facility policy titled Physician Order Entry was created and approved for use. All nursing staff and ordering providers shall receive education regarding the policy and procedure for proper order entry and confirmation that orders are appropriately mapped to MAR/TAR as indicated. IV. Unit Managers/DON or designee will conduct twice weekly audits of standard other reports x 4 weeks, then monthly x 3 months to ensure proper order entry. Discrepancies will be reported to the Director of Nursing (DON) with follow-up actions as necessary. The DON will report the findings quarterly to the QA Committee for the next two meetings, which will evaluate that the deficiency remains corrected and in compliance with regulatory requirements.	

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F 658	Continued From page 2 problem. On 06/13/2024 at 11:16 AM, during the initial tour of the facility the surveyor observed Resident #43 [redacted]. Resident #43 has a [redacted]. The [redacted] was observed to have [redacted] in the [redacted]. A [redacted] in place. Resident #43 denied any [redacted] when interviewed. According to the most recent Admission Record, Resident #43 was admitted to the facility with the following but not limited to diagnoses: [redacted]. According to the quarterly Minimum Date Set (MDS), an assessment tool, dated [redacted], Resident #43 had a brief Interview for Mental Status score of [redacted]/15, which indicated [redacted]. According to section GG Resident #43 required was [redacted] on staff for most activities of daily living except [redacted] Section H revealed that Resident #43 had an [redacted] and Section I revealed that Resident #43 had an active diagnosis of [redacted] A review of the electronic medical record (EMR) of Resident #43 under the "Orders" section of the EMR revealed that Resident #43 had the following order dated [redacted]: "[redacted] to PCR [redacted] for [redacted] /R/o [redacted] The surveyor then reviewed the "Results" section of	F 658		

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F 658	Continued From page 3	F 658		

the EMR to obtain the results of the NJ Ex Order 26.4(b)(1) ordered NJ Ex Order 26.4(b)(to assess Resident #43. A review of the results section did not contain a NJ Ex Order 26.4(b)(conducted on or after NJ Ex Order 26.4(b)(1).

A review of Resident #43's comprehensive care plan revealed the following Focus: Potential for NJ Ex O AEB (as evidenced by) hx (history) of NJ Ex Or Resident #43 had the following care plan Goal: [resident name] will remain free from s/s (signs/symptoms) NJ Ex Or revised on: NJ Ex Order 26.4(b)(1). Resident #43 had the following but not limited to Interventions/Tasks: Monitor labs as ordered, keep MD aware of abnormalities. Date Initiated: NJ Ex Order 26.4(b)(1).

On 06/18/24 at 01:40 PM, the surveyor requested a copy of the NJ Ex and copy of NJ Ex Order 26 policy from the facility U.S. FOIA (b) (6).

On 06/19/2024 at 09:36 AM, the surveyor conducted an interview with the facility U.S. FOIA (b The U.S. FOIA could not provide the surveyor with a copy of the results of Resident #43's NJ Ex Order 26.4(b)(ordered on NJ Ex Order 26.4(b)(1) by the U.S. FOIA (b) (6)). The U.S. FOIA explained, "I realized that there was no documentation since NJ Ex Order 26.4(b)(1). I reached out to the U.S. F to find out why the NJ Ex Order 26.4(b was ordered. The U.S. F said that it was written in error. We educated NJ Ex C and NJ Ex admitted that it was written in error." The surveyor then asked if facility staff addressed the order from NJ Ex Order 26.4(b)(1) prior to the surveyor making the facility aware that there was no result for the lab. Did anybody in the facility address the order? The U.S. FOIA responded, "No." The surveyor then asked the U.S. FOIA what the facility practice was for responding to a physician/practitioner order. The U.S. FOIA replied,

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F 658	Continued From page 4 "The nurse should ask the U.S. FOIA (b) (6). The U.S. FO was not aware that there was an order for the NJ Ex Order 26.4(b). The surveyor asked the U.S. FOIA if the order should have been addressed on NJ Ex Order 26.4(b)(1). The U.S. FOIA acknowledged that yes it should have been addressed on the by facility staff. The U.S. FOIA agreed that the facility staff should have addressed the order on NJ Ex Order 26.4(b) because the order was visible under the "Orders" tab in the EMR and that the 11-7 nurse should have picked up on the order during their 24 hour chart check. The facility was unable to provide a policy or procedure for physician orders when requested by the surveyor. NJAC 8:39-27.1(a)	F 658		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with	F 725		7/26/24

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F 725	Continued From page 5 resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interviews, review of the Nurse Staffing Report and the PB&J (Payroll Based Journal) report and other facility documentation, it was determined that the facility failed to ensure there was sufficient nursing staff on a 24-hour basis to provide nursing care to the residents. This deficient practice was evidenced by the following: 1. For the week of Complaint staffing from 03/05/2024 to 03/11/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -03/05/23 had 11 CNAs for 170 residents on the day shift, required at least 21 CNAs. -03/06/23 had 14 CNAs for 168 residents on the day shift, required at least 21 CNAs. -03/07/23 had 14 CNAs for 166 residents on the day shift, required at least 21 CNAs. -03/08/23 had 17 CNAs for 166 residents on the day shift, required at least 21 CNAs. -03/09/23 had 20 CNAs for 165 residents on the day shift, required at least 21 CNAs. -03/10/23 had 19 CNAs for 165 residents on the day shift, required at least 21 CNAs.	F 725	On 6/27/24, Resident #161 was provided with information on how/when it is appropriate to file a grievance at the facility, as staff was unaware of Resident #161 concerns relating to staff response time. On 6/19/24, facility staff met with resident #145 related to NJ Ex O indication he/she must wait a long time for assistance. Resident #145 was offered and agreed to a room change NJ Ex Order 26.4(b)(1) [redacted]. Additionally, a call bell audit log was initiated on 6/19/24 to monitor staff response time to call bell. Resident #145 did not ring NJ Ex O call bell for the 24-hour period of monitoring. Director of Nursing meets daily and before weekends with staffing coordinator to review staff sufficiency. Staffing coordinator sends daily email with the staffing numbers to the Administrator and Director of Nursing. II. All residents in the facility have the potential to be affected by this deficient practice. A random sample of 20 alert and oriented residents were interviewed regarding staff	

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F 725	Continued From page 6 -03/11/23 had 16 CNAs for 163 residents on the day shift, required at least 20 CNAs. 2. For the week of Complaint staffing from 04/02/2023 to 04/08/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -04/02/23 had 14 CNAs for 173 residents on the day shift, required at least 22 CNAs. -04/03/23 had 15 CNAs for 173 residents on the day shift, required at least 22 CNAs. -04/04/23 had 16 CNAs for 173 residents on the day shift, required at least 22 CNAs. -04/05/23 had 14 CNAs for 172 residents on the day shift, required at least 21 CNAs. -04/06/23 had 19 CNAs for 172 residents on the day shift, required at least 21 CNAs. -04/07/23 had 20 CNAs for 172 residents on the day shift, required at least 21 CNAs. -04/08/23 had 15 CNAs for 172 residents on the day shift, required at least 21 CNAs. 3. For the week of Complaint staffing from 08/27/2023 to 09/02/2023, the facility was deficient in CNA staffing for residents on 6 of 7-day 0shifts, deficient in total staff for residents on 1 of 7 evening shifts, and deficient in CNAs to total staff on 1 of 7 evening shifts as follows: -08/27/23 had 7 CNAs for 180 residents on the day shift, required at least 22 CNAs. -08/27/23 had 12 total staff for 180 residents on the evening shift, required at least 18 total staff. -08/27/23 had 4 CNAs to 12 total staff on the evening shift, required at least 6 CNAs. -08/28/23 had 15 CNAs for 180 residents on the day shift, required at least 22 CNAs. -08/29/23 had 17 CNAs for 180 residents on the	F 725	response times to requests for assistance, with concerns reported to the Director of Nursing for rectification. III. The facility currently has contracts with 6 Nursing Agencies. Daily bonuses are offered for double shifts, extra shifts, weekend shifts, and staff recognition. The daily bonus range was reviewed and increased. Referral and sign-on bonuses are offered. The call out Policy has been reviewed and the staff has been re-educated. The facility is recruiting on multiple employment search engines and multiple social media platforms. we also have a recruiter to help us get staff. Depending on the needs of the day Nursing management to include Unit Mangers, Supervisors and ADON will be evaluated to assist with resident care. Rates have been increased for CNAs. The facility has partnered with a CNA school to hire new graduates to increase staff. IV. Alert and oriented residents will be interviewed regarding timeliness of staff response when requesting help as part of their quarterly care conference meetings. This data will be reported by Social Services Quarterly to the QA Committee for the next two meetings, which will evaluate that the deficiency remains corrected and in compliance with regulatory requirements.	

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F 725	Continued From page 7	F 725		

day shift, required at least 22 CNAs.
-08/31/23 had 16 CNAs for 186 residents on the day shift, required at least 23 CNAs.
-09/01/23 had 17 CNAs for 185 residents on the day shift, required at least 23 CNAs.
-09/02/23 had 14 CNAs for 185 residents on the day shift, required at least 23 CNAs.

4. For the week of Complaint staffing from 09/10/2023 to 09/16/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:

-09/10/23 had 13 CNAs for 194 residents on the day shift, required at least 24 CNAs.
-09/11/23 had 16 CNAs for 194 residents on the day shift, required at least 24 CNAs.
-09/12/23 had 17 CNAs for 193 residents on the day shift, required at least 24 CNAs.
-09/13/23 had 15 CNAs for 192 residents on the day shift, required at least 24 CNAs.
-09/14/23 had 15 CNAs for 192 residents on the day shift, required at least 24 CNAs.
-09/15/23 had 15 CNAs for 192 residents on the day shift, required at least 24 CNAs.
-09/16/23 had 15 CNAs for 192 residents on the day shift, required at least 24 CNAs.

5. For the week of Complaint staffing from 11/19/2023 to 11/25/2023, the facility was deficient in CNA staffing for residents on 7 of 7-day shifts, deficient in total staff for residents on 1 of 7 evening shifts, and deficient in total staff for residents on 1 of 7 overnight shifts as follows:

-11/19/23 had 9 CNAs for 186 residents on the day shift, required at least 23 CNAs.
-11/20/23 had 13 CNAs for 185 residents on the day shift, required at least 23 CNAs.

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F 725	Continued From page 8	F 725		

-11/21/23 had 13 CNAs for 185 residents on the day shift, required at least 23 CNAs.
-11/22/23 had 14 CNAs for 185 residents on the day shift, required at least 23 CNAs.
-11/23/23 had 15 CNAs for 183 residents on the day shift, required at least 23 CNAs.
-11/23/23 had 16.5 total staff for 183 residents on the evening shift, required at least 18 total staff.
-11/23/23 had 10 total staff for 183 residents on the overnight shift, required at least 13 total staff.
-11/24/23 had 11 CNAs for 183 residents on the day shift, required at least 23 CNAs.
-11/25/23 had 12 CNAs for 183 residents on the day shift, required at least 23 CNAs.

6. For the week of Complaint staffing from 01/07/2024 to 01/13/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:

-01/07/24 had 12 CNAs for 185 residents on the day shift, required at least 23 CNAs.
-01/08/24 had 13 CNAs for 184 residents on the day shift, required at least 23 CNAs.
-01/09/24 had 13 CNAs for 184 residents on the day shift, required at least 23 CNAs.
-01/10/24 had 17 CNAs for 184 residents on the day shift, required at least 23 CNAs.
-01/11/24 had 20 CNAs for 184 residents on the day shift, required at least 23 CNAs.
-01/12/24 had 22 CNAs for 184 residents on the day shift, required at least 23 CNAs.
-01/13/24 had 14 CNAs for 184 residents on the day shift, required at least 23 CNAs.

7. For the week of Complaint staffing from 02/18/2024 to 02/24/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:

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F 725	Continued From page 9	F 725		

-02/18/24 had 13 CNAs for 183 residents on the day shift, required at least 23 CNAs.
-02/19/24 had 10 CNAs for 183 residents on the day shift, required at least 23 CNAs.
-02/20/24 had 12 CNAs for 183 residents on the day shift, required at least 23 CNAs.
-02/21/24 had 14 CNAs for 183 residents on the day shift, required at least 23 CNAs.
-02/22/24 had 15 CNAs for 183 residents on the day shift, required at least 23 CNAs.
-02/23/24 had 16 CNAs for 183 residents on the day shift, required at least 23 CNAs.
-02/24/24 had 13 CNAs for 182 residents on the day shift, required at least 23 CNAs.

8. For the week of Complaint staffing from 03/17/2024 to 03/23/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:

-03/17/24 had 13 CNAs for 177 residents on the day shift, required at least 22 CNAs.
-03/18/24 had 12 CNAs for 177 residents on the day shift, required at least 22 CNAs.
-03/19/24 had 12 CNAs for 177 residents on the day shift, required at least 22 CNAs.
-03/20/24 had 15 CNAs for 177 residents on the day shift, required at least 22 CNAs.
-03/21/24 had 17 CNAs for 174 residents on the day shift, required at least 22 CNAs.
-03/22/24 had 16 CNAs for 174 residents on the day shift, required at least 22 CNAs.
-03/23/24 had 12 CNAs for 174 residents on the day shift, required at least 22 CNAs.

9. For the week of Complaint staffing from 04/28/2024 to 05/04/2024, the facility was deficient in CNA staffing for residents on 7 of 7

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F 725	Continued From page 10	F 725		

day shifts as follows:

-04/28/24 had 15 CNAs for 181 residents on the day shift, required at least 23 CNAs.
-04/29/24 had 11 CNAs for 181 residents on the day shift, required at least 23 CNAs.
-04/30/24 had 13.5 CNAs for 181 residents on the day shift, required at least 23 CNAs.
-05/01/24 had 15 CNAs for 181 residents on the day shift, required at least 23 CNAs.
-05/02/24 had 16 CNAs for 180 residents on the day shift, required at least 22 CNAs.
-05/03/24 had 14.5 CNAs for 180 residents on the day shift, required at least 22 CNAs.
-05/04/24 had 16 CNAs for 179 residents on the day shift, required at least 22 CNAs.

10. For the 2 weeks of staffing prior to survey from 05/26/2024 to 06/08/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:

-05/26/24 had 14 CNAs for 184 residents on the day shift, required at least 23 CNAs.
-05/27/24 had 13 CNAs for 183 residents on the day shift, required at least 23 CNAs.
-05/28/24 had 11 CNAs for 183 residents on the day shift, required at least 23 CNAs.
-05/29/24 had 16 CNAs for 182 residents on the day shift, required at least 23 CNAs.
-05/30/24 had 15 CNAs for 182 residents on the day shift, required at least 23 CNAs.
-05/31/24 had 18 CNAs for 182 residents on the day shift, required at least 23 CNAs.
-06/01/24 had 15 CNAs for 182 residents on the day shift, required at least 23 CNAs.

-06/02/24 had 11 CNAs for 187 residents on the day shift, required at least 23 CNAs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315260	A. BUILDING _____ B. WING _____	C 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	600 PEMBERTON BROWN MILLS RD PEMBERTON, NJ 08068

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F 725	Continued From page 11	F 725		

-06/03/24 had 15 CNAs for 187 residents on the day shift, required at least 23 CNAs.
-06/04/24 had 14 CNAs for 187 residents on the day shift, required at least 23 CNAs.
-06/05/24 had 16 CNAs for 187 residents on the day shift, required at least 23 CNAs.
-06/06/24 had 9 CNAs for 187 residents on the day shift, required at least 23 CNAs.
-06/07/24 had 15.5 CNAs for 187 residents on the day shift, required at least 23 CNAs.
-06/08/24 had 14 CNAs for 189 residents on the day shift, required at least 24 CNAs.

On 06/13/24 at 10:28 AM, during an interview with the surveyor, the US FOIA (b)(6) (LPN/UM #4) when asked how staffing has been, replied, "So-so, it could be better some days." At that time the LPN/UM #4 provided the Dogwood Court Assignment Sheet for the 7-3 shift that revealed a census of 58 residents with four CNA's indicating a ratio of 1 CNA to 15 residents.

During an interview with the surveyor on 06/18/24 at 10:24 AM, CNA #3 stated that he/she had 14 residents on his/her assignment. When asked, can you get all your work done on your 8 hours shift, CNA #3 stated, "If I move fast enough, we only have 2 CNAs on the unit."

On 06/13/24 at 10:41 AM, Resident #161 stated that call bells are not answered timely, and his/her roommate has waited up to 7 hours for assistance. Resident #161 added that at times, he/she must find help for NJ Ex(roommate and other residents when call bells go unanswered for long periods of time.

On 06/13/24 at 11:59 AM, during an interview with

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F 725	Continued From page 12 the surveyor, Resident #145 stated that he/she must wait a long time for assistance. During an interview with the surveyor on 06/18/2024 at 11:03 AM, the U.S. FOIA (b) (6) indicated that it is difficult to meet the staffing requirements. The U.S. FOIA (b) (6) said that she was aware of the minimum staffing requirements for CNA's which is 1 to 8 residents for 7-3 shift, 1 to 10 residents for the 3-11 shift, and 1 to 14 for the 11-7 shift. We use agency staffing that is unreliable. We are not always able to meet staffing requirements. During an interview with the surveyor on 06/18/2024 at 12:14 PM, CNA #2 stated, "I typically have between 12-15 residents on day shift. Weekends are the same. Today, I have 3 NJ Ex Order 2 lifts which requires 2 CNA's to safely transfer; it is difficult to get assistance when staffing is limited. When asked, if he/she was able to complete all assignments during his/her shift, he/she replied, "no." On 06/19/2024 at 12:33 PM, in the presence of the survey team, the U.S. FOIA (b) (6)) stated the facility staffing is determined by the New Jersey Department Of Health (NJDOH) requirements which are, 1:8 for 7-3 shift, 1:10 for 3-11 shift and 1:14 for 11-7 shift. The U.S. FOIA acknowledged that the facility was not meeting those requirements. The U.S. FOIA added that based on a full census of 204 residents, the staffing plan for CNA's is 4-5 on larger units: Dogwood and Birch during the day, 3 CNA's for SMART Unit, 2 CNA's for Oak unit, a 1 CNA for Laurel Unit. A review of the Facility Assessment dated 03/14/24, under supportive documentation,	F 725		

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F 725	Continued From page 13 revealed the following: Under "Direct Care Staff (Certified Nurse Aides) 8 Aides Birch Court 7-3 and 5 Aides on 3-11; 3 Aides on 11-7 8 Aides Dogwood 7-3 and 5 Aides on 3-11; 3 Aides on 11-7 4 Aides on SMART Unit all three shifts 2 Aides on Laurel Unit all three shifts 4 Aides on Oak Court 7-3 and 3-11; 3 aides on 11-7 A review of a policy provided by the facility titled, "Nursing Policy and Procedure," with a revision date of June 2020 and a review date of January 2024, revealed; "It is the policy of this facility to determine the appropriate staffing on a unit based on the census, acuity, shift and needs of the residents and staffing ratio required by the NJDOH. NJAC 8:39-5.1(a), 27.1(a)	F 725		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		7/26/24

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F 755	Continued From page 14 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined the facility failed to accurately document the administration of NJ Ex Order 26.4(b)(1) for 7 sampled residents, (Resident #11, Resident #30, Resident #49, Resident #60, Resident #69, Resident #120 and Resident #128) identified upon inspection of 2 of 4 medication carts (Birch Unit A cart, and Birch Unit B cart). This deficient practice was evidenced by the following: On 6/18/2024 at 1:10 PM, the surveyor in the presence of the Licensed Practical Nurse #3 (LPN #3) inspected Birch unit, A cart. The surveyor and LPN #3 reviewed the NJ Ex Order 26.4 medication located in the secured and locked NJ Ex Order 26.4 box. When the NJ Ex Order 26.4 inventory sheet,	F 755	Corrective Action I.On 6/18/2024, LPN #3 and Unit Manager reconciled NJ Ex Order 26.4 medications by looking at the medication blister packaging, the MAR, and the declining inventory sheets to ensure the NJ Ex Order 26.4 counts were correct. On 6/18/2024, LPN #1 and Unit Manager reconciled NJ Ex Order 26.4 medications by looking at the medication blister packaging, the MAR, and the declining inventory sheets to ensure the NJ Ex Order 26.4 counts were correct. Both LPN #1 and #3 received education on 6/18/2024 regarding proper administration of controlled substances according to facility policy. Residents #11, #30, #49, #60, #69, #120, and #128 had NJ Ex Order 26.4(b)(1)	

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	315260	A. BUILDING _____ B. WING _____	C 06/20/2024

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F 755	Continued From page 15 the surveyor identified the following concerns: Resident #60's NJ Ex Order 26.4(b)(1) capsule, a medication used for [redacted], did not match the physical inventory. The blister pack contained [redacted] capsules and the declining inventory sheet indicated there should be [redacted] capsules remaining. Resident #69's NJ Ex Order 26.4(b)(1) capsules also did not match. The blister pack contained [redacted] capsules and the declining inventory sheet indicated there should be [redacted] capsules remaining. At that time, the surveyor interviewed the LPN #3 who stated she had administered the medications earlier to both residents and had not signed the declining inventory sheet for the doses she had administered. The LPN acknowledged the declining inventory sheet should be signed when the medication was removed from the packaging. On 6/18/2024 at 1:29 PM, the surveyor in the presence of the Licensed Practical Nurse #1 (LPN #1) inspected Birch unit, B cart. The surveyor and LPN #1 reviewed the [redacted] medication located in the secured and locked [redacted] box. When the [redacted] inventory was compared to the corresponding declining inventory sheet, the surveyor identified the following concerns: Resident #11's NJ Ex Order 26.4(b)(1) [redacted] tablet, a medication used for [redacted], did not match the physical inventory. The blister pack contained [redacted] tablets and the declining inventory sheet indicated there should be [redacted] tablets remaining.	F 755	related to the findings. II. All residents who receive controlled substances have the potential to be affected by this deficient practice. Audits were completed on all medication carts to ensure accurate reconciliation of controlled substances. III. All licensed nursing staff will be re-educated by 7/26/24 regarding the Policy and Procedure for Medication Dispensing; Controlled Substances. IV. A weekly random sample of 10 residents receiving controlled medications will be reviewed by the DON (or designee) x 4 weeks, then monthly x 3 months for accuracy of the declining inventory sheets. Non-compliant documentation found during audits shall be reviewed immediately with the Unit Manager for rectification. IV. The DON will report the findings quarterly to the QA Committee for the next two meetings, which will evaluate that the deficiency remains corrected and in compliance with regulatory requirements.	

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	315260	A. BUILDING _____ B. WING _____	C 06/20/2024

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F 755	Continued From page 16 Resident #30's NJ Ex Order 26.4(b)(1) tablet, a medication used for NJ Ex Order 26.4 did not match the physical inventory. The blister pack contained NJ Ex O tablets and the declining inventory sheet indicated there should be NJ E tablets remaining. Resident #49's NJ Ex Order 26.4(b)(1) capsule, did not match the physical inventory. The blister pack contained NJ capsules and the declining inventory sheet indicated there should be NJ E capsules remaining. Resident #120's NJ Ex Order 26.4(b)(1) tablet, a medication used for NJ Ex Order 26.4(b)(1) did not match the physical inventory. The blister pack contained NJ Ex O tablets and the declining inventory sheet indicated there should be NJ E tablets remaining. Resident #128's NJ Ex Order 26.4(b)(1) capsule, a medication used for NJ Ex Order 26.4(b)(1), did not match the physical inventory. The blister pack contained NJ Ex O capsules and the declining inventory sheet indicated there should be NJ E capsules remaining. At that time, the surveyor interviewed LPN #1 who stated she had given the medications earlier and should have signed the declining inventory sheets when she removed the medications from their packaging. On 6/18/2024 at 1:56 PM, the surveyor interviewed the Unit Manager Licensed Practical Nurse #3 (UM/LPN #3) who stated the nurse should be signing the declining inventory sheets at the time they remove the medication from inventory. On 6/20/2024 at 11:09 AM, the survey team met	F 755		

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F 755	Continued From page 17 with facility Administration. The U.S. FOIA (b) (6) [redacted] stated nurses should be signing the declining inventory sheets as soon as the medication was removed from the packaging. A review of the facility's undated "Medication Dispensing; Controlled Substances" policy included... Accountability of controlled dangerous substances... When a CDS (controlled Dangerous Substance) medication is administered... the nurse must document on the declining inventory sheet the date of administration, the quantity administered, the amount of medication remaining and his/her initials. A review of the facility's undated "Medication Administration General Guidelines for the Administration of Medications" policy included... Administration of controlled Dangerous substances is also recorded on the declining inventory form. NJAC 8:39-29.2(d), 29.7(c)	F 755		
F 812 SS=E	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	F 812		7/26/24

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F 812	Continued From page 18 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 other pertinent facility documents, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 6/13/2024 from 9:30 to 10:23 AM, the surveyors, accompanied by the U.S. FOIA (b) (6) [redacted]), observed the following in the kitchen: 1. On an upper shelf, a previously opened bag of egg noodles had no opened or use by dates. The U.S. FOIA [redacted] removed the noodles from storage. 2. In the paper storage area on a middle shelf a previously opened plastic bag of coffee filters was stored opened and exposed. The U.S. FOIA [redacted] removed the filters from storage. 3. A clean and sanitized stand-up mixer in the food production area was covered with plastic and not in use per the U.S. FOIA [redacted] The U.S. FOIA [redacted] removed the plastic covering. The surveyor observed unidentified food debris on the support arm of the mixer behind the bowl and above the beater shaft. The U.S. FOIA [redacted] stated, "I'll have that re-cleaned	F 812	I.On 6/13/2024: -An opened bag of egg noodles was removed and discarded. -An opened bag of coffee filters was removed and discarded. -The stand-up mixer was cleaned and sanitized. A do not use sign was placed on the mixer as this equipment is not utilized by facility. -A trash-can designated for the handwashing sink was returned to its appropriate location. -Two NJ Ex Order 26.4(b)(1) [redacted] Vanilla shakes were removed and discarded. -An opened roll of liverwurst was removed and discarded. On 6/18/2024, an unlabeled NJ Ex Order [redacted] bag with pizza and 2 condiment cups were removed from the Laurel Court Pantry refrigerator and discarded. An internal thermometer was placed in the freezer. LPN #5 received re-education on the Food Safety Education Policy and proper monitoring/recording of freezer temperatures in resident pantries.	

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	315260	A. BUILDING _____ B. WING _____	C 06/20/2024

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F 812	Continued From page 19 and sanitized." 4. After observing the Starter Refrigerator, the surveyor went to the designated hand washing sink in the kitchen. Upon completion of hand washing and drying their hands the surveyor attempted to throw their used hand towel into the trash. There was no waste can at the sink. The U.S. FOIA stated that the waste can was removed from the area. to be emptied and showed the surveyor the waste can that was located near the tray line. Observation of the waste can contents did not reveal any used hand towels in the contents. 5. The Beverage Box contained two (2) NJ Ex Order 2 Vanilla shakes (a nutritional supplement) that had a date of "6-8." When interviewed the U.S. FOIA stated, "They are good for 14 days once pulled from the freezer. They are old. I'm discarding them." 6. In Walk-In refrigerator #4 on a lower shelf a previously opened roll of liverwurst was wrapped in plastic wrap. The liverwurst had no dates. The U.S. FOIA removed the liverwurst to the trash. On 06/18/2024 at 9:18 AM, the surveyors made the following observations in the Laurel Unit designated resident pantry: 1. Review of the [facility name] "DATES/TEMPERATURE SHEET" with MONTH: 6/2024, revealed the following: Freezer Temps: 0 Degrees or Below "ALL ITEMS MUST BE DATED" 2. Observation of the freezer revealed that the	F 812	II. All residents in the facility have the potential to be affected by the deficient practice. III. All foodservice employees were re-educated on the facility policies for Receiving, Equipment, and Food Storage: Dry Goods. All licensed nursing staff was re-educated regarding the Food Safety Education Policy and proper monitoring/recording of freezer temperatures in resident pantries. IV. The Foodservice Director/Designee will conduct audits weekly x 4 weeks, then monthly x 3 months to ensure proper storing/labeling/dating of potentially hazardous food items. The Foodservice Director/Designee will conduct audits weekly x 4 weeks, then monthly x 3 months to ensure all foodservice equipment is clean, sanitary, and in proper working order. The Unit Manager/Designee will conduct audits weekly x 4 weeks, then monthly x 3 months to ensure proper labeling/dating of food stored in resident pantries. The Unit Manager/Designee will conduct audits weekly x 4 weeks, then monthly x 3 months to ensure proper monitoring and documentation of freezer temperatures in resident pantries. The Foodservice Director will report the findings quarterly to the QA Committee for the next two meetings, which will evaluate	

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F 812	Continued From page 20 freezer did not contain an internal thermometer to monitor the freezer temperature. In addition, no freezer temperatures were recorded on the temperature sheet. 3. The surveyor observed a single slice of pizza on the bottom shelf of the refrigerator. The pizza was in a [redacted] bag and had no dates. On the shelf of the refrigerator door two (2) separate plastic portion control cups contained an unidentified white sauce and one contained a red/orange sauce that appeared to be hot sauce. The portion control cups had no dates. On interview Licensed Practical Nurse (LPN #5) agreed that all foods require a name and use by date. The surveyor made LPN #5 aware that freezer temperatures had to monitored, in addition to refrigerator temperatures. LPN #5 replied, "Ok." The surveyor reviewed the facility policy titled [facility name] Policy and Procedure Food Safety Education, April 2018. The following was revealed under POLICY: Residents are permitted to store and consume food that is obtained from outside the center. As a result, it is the policy of this facility to: Provide storage space for outside food/beverages that are distinct from the facility food storage units. The policy also had an attachment that revealed the following: All food and beverage items stored in the facility pantry/refrigerator must be thrown out:	F 812	that the deficiency remains corrected and in compliance with regulatory requirements.	

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	315260	A. BUILDING _____ B. WING _____	C 06/20/2024

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F 812	Continued From page 21	F 812		

1. On the manufacturer's expiration date.
2. 72 hours after the date it was brought in.
3. Upon spoiling.

In addition, the attachment also revealed that "Facility is responsible for discarding any expired, spoiled, or unlabeled food that is discovered" and "All food and beverage items being stored in the facility pantry or refrigerator must be: Labeled with the resident's name and Labeled with the date brought in (unless the items are in their original containers marked with a manufacturer's expiration date).

The surveyor reviewed a facility policy titled Receiving, with Revised dated of 9/2017. The following was revealed under the heading Policy Statement: Safe food handling procedures for time and temperature control will be practiced in the transportation, delivery, and subsequent storage of all food items.

The following was revealed under Procedures:

5. All food items will be appropriately labeled and dated either through manufacturer packaging or staff notation.

The surveyor reviewed the facility policy titled Equipment, Revised 9/2017. The following was revealed under the heading Policy Statement: All foodservice equipment will be clean, sanitary, and in proper working order.

The following was revealed under the heading Procedures:

2. All staff members will be properly trained in the cleaning and maintenance of all equipment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 22 3. All food contact equipment will be clean and free of debris. The surveyor reviewed the facility policy titled Food Storage: Dry Goods, Revised 2/2023. The policy revealed the following under Policy Statement: All dry goods will be appropriately stored in accordance with the FDA Food Code. The following was revealed under the heading Procedures: 6. Storage areas will be neat, arranged for easy identification, and date marked as appropriate.	F 812		
F 880 SS=D	NJAC 18:39-17.2 (g) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		7/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315260	A. BUILDING _____ B. WING _____	C 06/20/2024

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F 880	Continued From page 23 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

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F 880	Continued From page 24 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of medical records and other facility documentation, it was determined that the facility failed to follow appropriate infection control procedures: 1) during the provision of a NJ Ex Order 26 treatment and 2) during medication administration. This deficient practice was identified for 1 of 1 nurses Registered Nurse (RN #1) who administered a NJ Ex Order 26.4b1 to 1 of 2 residents (Resident #177) reviewed for NJ Ex Order 26.4(b)(1) and for 1 of 3 nurses Licensed Practical Nurse (LPN #2) observed during the medication administration observation. This deficient practice was evidenced by the following: 1. On 06/18/2024 at 10:21 AM, Surveyor #1 observed a stop sign posted outside of Resident #177's room which indicated the resident was on NJ Ex Order 26.4(b)(1)), which required use of both gown and gloves during high-contact resident care activities that provided opportunities for transfer of multi-drug resistant organisms (MDRO), bacteria that are resistant to three or more classes of antimicrobial drugs, to staff hands and clothing. The sign cautioned that everyone must: Clean their hands, including before entering and when leaving the room, and providers and staff must also wear gloves and	F 880	I.On 6/18/2024, RN #1 was re-educated regarding handwashing and a handwashing competency/return demonstration was performed in the presence of the ADON. On 6/18/2024, RN #1 was re-educated regarding Infection Prevention techniques during wound care and a Wound Treatment competency/return demonstration was performed in the presence of the ADON. On 6/18/2024, RN #1 was re-educated regarding Enhanced Barrier Protections. On 6/18/2024, LPN #2 was re-educated regarding Infection Prevention techniques and Handwashing during Medication Administration. A handwashing competency/return demonstration was completed in the presence of the ADON. Residents #177 and #81 had NJ Ex Order 26.4b1 related to the findings. II. All residents in the facility have the potential to be affected by this deficient practice. III. All licensed nursing staff will be re-educated by 7/26/24 regarding the Policy and Procedure for Enhanced Barrier Precautions, Wound Treatment Procedure, and Proper Handwashing Procedure.	

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F 880	Continued From page 25 gowns for the following high-contact resident care activities: ...[NJ Ex Order 26] care: any [NJ Ex Order 26.4(b)(1)] requiring a [NJ Ex Order 26.4(b)] Beneath the stop sign there was a cart that contained Personal Protective Equipment (PPE), (equipment worn to protect the body from infection). The surveyors entered the room and observed the resident seated in a wheelchair at the bedside. The resident stated that he/she had a [NJ Ex Order 26] near their [NJ Ex Order 26.4] and was agreeable to permit the surveyors to observe [NJ Ex Order 26] treatment. On 06/18/2024 at 10:58 AM, Surveyor #1 observed RN #1 wash her hands for 15 seconds before she donned (put on) gloves, and failed to donn a gown as indicated on the signage outside of Resident #177's room, before she proceeded to remove the resident's NJ Ex Order 26.4(b)(1) [redacted]. At 10:59 AM, RN #1 performed hand hygiene with alcohol based hand rub (ABHR) before she donned gloves and proceeded to cleanse the resident's [NJ Ex Order 26.4(b)(1)] with [NJ Ex Order 26.] Solution (a mixture of sodium peroxide and hydrochloric acid). RN #1 patted the [NJ Ex Order 26] dry, applied [NJ Ex Ord] [redacted] (adhesive aid) to the border of the [NJ Ex Order 26.4] and cut a piece of NJ Ex Order 26.4(b)(1) [redacted] to size before she placed it in the [NJ Ex Order 26.4(b)(1)] and covered it with a border foam dressing. At 11:03 AM, after RN #1 finished Resident #177's [NJ Ex Order 26] treatment she opened the door with her gloved hand, doffed (removed) her gloves and discarded them, before she proceeded to obtain a disinfectant wipe from the treatment cart and wiped down the marker used to date the dressing and the scissors used to cut	F 880	IV. A random sample of 5 employees will be monitored for proper hand hygiene weekly x 4 weeks, then monthly x 3 months by the Infection Preventionist or designee. Deficient practice found during audits shall be reviewed immediately and reported to the DON for rectification. A random sample of 5 employees will be monitored for proper PPE while caring for residents on Enhanced Barrier Precautions weekly x 4 weeks, then monthly x 3 months by the Infection Preventionist or designee. Deficient practice found during audits shall be reviewed immediately and reported to the DON for rectification. A random sample of 5 wound treatments will be monitored weekly x 4 weeks, then monthly x 3 months for proper Infection Prevention techniques by the Infection Preventionist or designee. Deficient practice found during audits shall be reviewed immediately and reported to the DON for rectification. The DON will report the findings quarterly to the QA Committee for the next two meetings, which will evaluate that the deficiency remains corrected and in compliance with regulatory requirements.	

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F 880	Continued From page 26	F 880		

the [NJ Ex Order 26] treatment to size. RN #1 then donned gloves without first performing hand hygiene, placed the scissors in a plastic bag, reached into her pocket with her gloved hands and obtained the keys to the treatment cart and accessed the treatment cart, and the computer that was located on top of the treatment cart.

At 11:05 AM, RN #1 doffed her gloves and washed her hands for ten seconds before she signed the treatment as administered in the computer.

At 11:07 AM, RN #1 obtained the garbage bag from Resident #177's room that contained soiled [NJ Ex Order 26.4b1] supplies and placed the bag in the soiled utility room.

At 11:08 AM, the surveyor observed RN #1 as she washed her hands for 13 seconds.

At 11:10 AM, when interviewed about what PPE needed to be worn during a [NJ Ex Order 26] treatment for a resident on [NJ Ex Order 26.4(b)(1)], RN #1 stated staff were required to wear both a gown and gloves to protect their clothing. RN #1 then stated, "I did not put a gown on, did I ?" When interviewed about hand hygiene requirements RN #1 stated she was required to clean her hands prior to entry, before [NJ Ex Order 26.4(b)(1)], and after the [NJ Ex Order 26] treatment for 20 seconds. RN #1 stated she sang "Happy Birthday" once to ensure that she had washed her hands for a full 20 seconds. RN #1 stated hands would not be cleaned if they were washed for less than 20 seconds. RN #1 further stated there was a chance of contamination if she failed to wash her hands after she doffed her gloves [redacted] and then reached into her pocket and

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F 880	Continued From page 27 obtained the keys to the treatment cart, cleaned her scissors, marker and then accessed the treatment cart and computer. On 06/18/2024 at 11:26 AM, Surveyor #1 interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #2 who stated both a gown and gloves were needed for NJ Ex Order 26.4(b)(1) to prevent infection. LPN/UM #2 stated with direct care and touch, a gown should be worn as it could put the resident at risk for infection when care was rendered. LPN/UM #2 stated that hands were required to be washed for 30 seconds. LPN/UM #2 stated staff were required to wash their hands when gloves were doffed to ensure nothing got under the gloves. LPN/UM #2 further stated the main goal was infection prevention. On 06/18/2024 at 3:35 PM, Surveyor #1 interviewed the U.S. FOIA (b) (6)) who stated for NJ Ex Order 26.4(b)(1) staff should minimally wear a gown and gloves when NJ Ex Order 26.4b1 was rendered for a NJ Ex Order 26.4(b)(1). The U.S. stated if a gown were not worn there was a concern the nurse could give the resident an infection of some sort. The U.S. stated that if a resident were colonized (germs are on the body but do not make you sick) with an infection than the nurse risked infection as well. The U.S. stated the main concern was the patient. At that time, Surveyor #1 interviewed the U.S. regarding handwashing. The U.S. stated that staff were required to wash their hands for a minimum of 20 seconds and sing "Happy Birthday" twice. The U.S. stated if hands were washed for less than 20 seconds, then your hands were obviously not cleaned and you did not kill or get off the germs	F 880		

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F 880	Continued From page 28 that were possibly still on your hands. The [redacted] stated you could possibly contaminate everything you touched if your hands were not washed after you doffed your gloves post [redacted] because there was a possibility that an organism could be spread to the scissors or items that were cleaned and spread to the next person. The [redacted] stated the keys to the treatment cart were touched multiple times a day and were then passed off with the possibility for infection to spread down the line. On 06/19/2024 at 12:40 PM, Surveyor #1 interviewed the [redacted]) in the presence of the survey team, who stated [redacted] required both gloves and gown for the protection of the patient and staff during a [redacted] treatment. The [redacted] stated hand hygiene should be performed for 20 seconds or more, as there was a potential for contamination if hands were washed for less than 20 seconds. The [redacted] stated there was a chance of cross contamination if hands were not washed after gloves were doffed post [redacted] treatment. On 06/19/2024 at 11:09 AM, the [redacted] provided Surveyor #1 with RN #1's Hand Hygiene Competency Validation and Wound Treatment Observation Competency both of which were dated [redacted]. A review of a "Wound Treatment Observation " a tool the facility uses (revised 06/2022) revealed the following: ...Perform hand hygiene before beginning the procedure (rub hand [sic.] with soap for 20 seconds)	F 880		

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F 880	Continued From page 29 Put on gloves, loosen tape and remove soiled dressing, place in garbage. Wash hands and don gloves. (Rub hands with soap for 20 seconds). Pour cleaning solutions on gauze sponges. Cleanse wound and pat dry. Wash hands and don gloves (rub hands with soap for 20 seconds). Apply treatment as ordered. Cover wound with clean dressing (add the labeled dressing or tape). Remove gloves and Perform Hand hygiene. (rub hand [sic.] with soap for 20 seconds) *Sanatize [sic] pen Reposition resident if necessary and place call light within easy reach. Perform hand hygiene (rub hand [sic.] with soap for 20 seconds) Sanatize [sic.] over bed table. Perform Hand Hygiene (rub hand [sic.] with soap for 20 seconds) Discard garbage in soiled utility room. Perform hand hygiene (rub hand [sic.] with soap for 20 seconds)... 2. On 6/17/2024 from 8:05 AM through 8:31 AM, Surveyor #2, during the Medication Pass observation of LPN #2, made the following observations: LPN #2 was standing at her medication cart when Surveyor #2 approached her for medication pass observation. LPN #2 prepared the oral medications for Resident #135, set them aside and began preparing for the resident's NJ Ex Order 2 (NJ [redacted])	F 880		

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F 880	Continued From page 30 [redacted]. LPN #2 donned (put on) disposable gloves and administered the [redacted NJ Ex Order 2] to Resident #135. Once administered, LPN #2 doffed (removed) her gloves and without performing hand hygiene, proceeded to hand Resident #135 the prepared cup of oral medications as well as a cup of water. After completing medication pass for Resident #135, LPN #2 documented the medication administration in the computer and touched both the keyboard and the mouse, again without performing hand hygiene. LPN #2 then grasped the medication cart with both hands and wheeled the cart to the room of Resident #81. LPN #2 then proceeded to prepare Resident # 81's oral medication, without performing hand hygiene. LPN #2 then proceeded into Resident #81's room, administered their oral medications and after she exited Resident #81's room she performed hand hygiene using alcohol based hand rub (ABHR) at the medication cart. On 6/17/2024 at 8:31 AM, Surveyor #2 interviewed LPN #2 who acknowledged she should have performed hand hygiene before donning gloves and after doffing her gloves and between caring for Resident #135 and Resident #81, and confirmed not doing so was an infection control issue. On 6/20/2024 at 9:45 AM, Surveyor #2 interviewed the facility's U.S. FOIA (b) (6) [redacted] who stated LPN #2 should have performed hand hygiene before preparing the [redacted NJ Ex Order 26] [redacted] The [redacted U.S.] stated the nurse should have done hand hygiene first, then she should have gotten the [redacted NJ Ex Order 26.4(b)(1)] primed and ready, then used hand hygiene again and donn gloves, administered the mediation, removed her gloves and again performed hand hygiene, either	F 880		

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F 880	Continued From page 31 washing with soap and water or using ABHR. The [U.S.] stated nurses should always use hand hygiene between residents. On 6/20/2024 at 11:09 AM, the survey team met with the facility Administration which included the [U.S. FOIA (b)] who confirmed that staff should perform hand hygiene before and after wearing gloves and it must be performed between caring for each resident to prevent infection. A review of the facility provided "Medication Administration General Guidelines for the Administration of Medications" policy undated, included ... The nurse washes his/her hands appropriately before and after medication administration... A review of the facility provided "Medication Pass Observation" form revised 6/17, included... Hand washing (alcohol based hand rub or soap and water... between every resident even if patient contact is not made... immediately before and after use of gloves... A review of the facility provided untitled Hand Hygiene policy last reviewed 1/24, revealed the following: This facility considers hand hygiene the primary means to prevent the spread of infections. ... all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. ... the preferred method of hand hygiene is with alcohol-based hand rub... ...Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the	F 880		

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F 880	Continued From page 32 following conditions: before and after direct contact with residents...before donning sterile gloves... before preparing or handling medications...Before handling clean or soiled dressings, gauze pads, etc.;... after removing gloves...After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; and after removing gloves. Hand hygiene is always the final step after removing and disposing of personal protective equipment. The use of gloves does not replace handwashing/hand hygiene. A review of the facility policy, "Enhanced Barrier Precautions" (Created 03/25/24/Revised 06/19/24) revealed the following: Enhanced Barrier Precautions (EBP)-refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact activities. ...Examples of high-contact resident care activities requiring a gown and gloves for Enhanced Barrier Precautions include:...Wound care for chronic wounds requiring a dressing.... NJAC 8:39-19.4(n)	F 880		

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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: Complaint #'s NJ169221; NJ166868 Based on interview and review of other facility documents, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the dates below as mandated by the State of New Jersey and was evidenced by the following: 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	S 560	On 6/19/24, facility staff met with resident #145 related to her indication he/she must wait a long time for assistance. Resident #145 was offered and agreed to a room change closer to the nurses station. Additionally, a call bell audit log was initiated on 6/19/24 to monitor staff response time to call bell. Resident #145 did not ring [redacted] call bell for the 24-hour period of monitoring. Director of Nursing meets daily and before weekends with staffing coordinator to review staff sufficiency. Staffing coordinator sends daily emails with the staffing numbers to the Administrator and Director of Nursing. II. All residents in the facility have the	7/26/24

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

Electronically Signed | 07/02/24

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S 560	Continued From page 1 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. For the week of Complaint staffing from 03/05/2024 to 03/11/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -03/05/23 had 11 CNAs for 170 residents on the day shift, required at least 21 CNAs. -03/06/23 had 14 CNAs for 168 residents on the day shift, required at least 21 CNAs. -03/07/23 had 14 CNAs for 166 residents on the day shift, required at least 21 CNAs. -03/08/23 had 17 CNAs for 166 residents on the day shift, required at least 21 CNAs. -03/09/23 had 20 CNAs for 165 residents on the day shift, required at least 21 CNAs. -03/10/23 had 19 CNAs for 165 residents on the day shift, required at least 21 CNAs. -03/11/23 had 16 CNAs for 163 residents on the day shift, required at least 20 CNAs. 2. For the week of Complaint staffing from	S 560	potential to be affected by this deficient practice. A random sample of 20 alert and oriented residents were interviewed regarding staff response times to requests for assistance, with concerns reported to the Director of Nursing for rectification. III. The facility currently has contracts with 6 Nursing Agencies. Daily bonuses are offered for double shifts, extra shifts, weekend shifts, and staff recognition. The daily bonus range was reviewed and increased. Referral and sign-on bonuses are offered. The call out Policy has been reviewed and the staff has been re-educated. Advertisements signs are placed by bus stops in front of the building indicating the facility is actively hiring. The facility is recruiting on multiple employment search engines and multiple social media platforms. We also have a recruiter for the facility. Depending on the needs of the day Nursing management to include Unit Mangers, Supervisors and ADON will be evaluated to assist with resident care. Rates have been increased for CNAs. The facility has partnered with a CNA school to hire new graduates to increase staff. Alert and oriented residents will be interviewed regarding timeliness of staff response when requesting help as part of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060302	A. BUILDING: _____ B. WING _____	C 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	600 PEMBERTON BROWN MILLS RD PEMBERTON, NJ 08068

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S 560	Continued From page 2 04/02/2023 to 04/08/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -04/02/23 had 14 CNAs for 173 residents on the day shift, required at least 22 CNAs. -04/03/23 had 15 CNAs for 173 residents on the day shift, required at least 22 CNAs. -04/04/23 had 16 CNAs for 173 residents on the day shift, required at least 22 CNAs. -04/05/23 had 14 CNAs for 172 residents on the day shift, required at least 21 CNAs. -04/06/23 had 19 CNAs for 172 residents on the day shift, required at least 21 CNAs. -04/07/23 had 20 CNAs for 172 residents on the day shift, required at least 21 CNAs. -04/08/23 had 15 CNAs for 172 residents on the day shift, required at least 21 CNAs. 3. For the week of Complaint staffing from 08/27/2023 to 09/02/2023, the facility was deficient in CNA staffing for residents on 6 of 7-day shifts, deficient in total staff for residents on 1 of 7 evening shifts, and deficient in CNAs to total staff on 1 of 7 evening shifts as follows: -08/27/23 had 7 CNAs for 180 residents on the day shift, required at least 22 CNAs. -08/27/23 had 12 total staff for 180 residents on the evening shift, required at least 18 total staff. -08/27/23 had 4 CNAs to 12 total staff on the evening shift, required at least 6 CNAs. -08/28/23 had 15 CNAs for 180 residents on the day shift, required at least 22 CNAs. -08/29/23 had 17 CNAs for 180 residents on the day shift, required at least 22 CNAs. -08/31/23 had 16 CNAs for 186 residents on the day shift, required at least 23 CNAs. -09/01/23 had 17 CNAs for 185 residents on the day shift, required at least 23 CNAs.	S 560	their quarterly care conference meetings. This data will be reported by Social Services quarterly to the QA Committee for the next two meetings, which will evaluate that the deficiency remains corrected and in compliance with regulatory requirements.	

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S 560	Continued From page 3 -09/02/23 had 14 CNAs for 185 residents on the day shift, required at least 23 CNAs. 4. For the week of Complaint staffing from 09/10/2023 to 09/16/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -09/10/23 had 13 CNAs for 194 residents on the day shift, required at least 24 CNAs. -09/11/23 had 16 CNAs for 194 residents on the day shift, required at least 24 CNAs. -09/12/23 had 17 CNAs for 193 residents on the day shift, required at least 24 CNAs. -09/13/23 had 15 CNAs for 192 residents on the day shift, required at least 24 CNAs. -09/14/23 had 15 CNAs for 192 residents on the day shift, required at least 24 CNAs. -09/15/23 had 15 CNAs for 192 residents on the day shift, required at least 24 CNAs. -09/16/23 had 15 CNAs for 192 residents on the day shift, required at least 24 CNAs. 5. For the week of Complaint staffing from 11/19/2023 to 11/25/2023, the facility was deficient in CNA staffing for residents on 7 of 7-day shifts, deficient in total staff for residents on 1 of 7 evening shifts, and deficient in total staff for residents on 1 of 7 overnight shifts as follows: -11/19/23 had 9 CNAs for 186 residents on the day shift, required at least 23 CNAs. -11/20/23 had 13 CNAs for 185 residents on the day shift, required at least 23 CNAs. -11/21/23 had 13 CNAs for 185 residents on the day shift, required at least 23 CNAs. -11/22/23 had 14 CNAs for 185 residents on the day shift, required at least 23 CNAs. -11/23/23 had 15 CNAs for 183 residents on the day shift, required at least 23 CNAs.	S 560		

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S 560	Continued From page 4 -11/23/23 had 16.5 total staff for 183 residents on the evening shift, required at least 18 total staff. -11/23/23 had 10 total staff for 183 residents on the overnight shift, required at least 13 total staff. -11/24/23 had 11 CNAs for 183 residents on the day shift, required at least 23 CNAs. -11/25/23 had 12 CNAs for 183 residents on the day shift, required at least 23 CNAs. 6. For the week of Complaint staffing from 01/07/2024 to 01/13/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -01/07/24 had 12 CNAs for 185 residents on the day shift, required at least 23 CNAs. -01/08/24 had 13 CNAs for 184 residents on the day shift, required at least 23 CNAs. -01/09/24 had 13 CNAs for 184 residents on the day shift, required at least 23 CNAs. -01/10/24 had 17 CNAs for 184 residents on the day shift, required at least 23 CNAs. -01/11/24 had 20 CNAs for 184 residents on the day shift, required at least 23 CNAs. -01/12/24 had 22 CNAs for 184 residents on the day shift, required at least 23 CNAs. -01/13/24 had 14 CNAs for 184 residents on the day shift, required at least 23 CNAs. 7. For the week of Complaint staffing from 02/18/2024 to 02/24/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -02/18/24 had 13 CNAs for 183 residents on the day shift, required at least 23 CNAs. -02/19/24 had 10 CNAs for 183 residents on the day shift, required at least 23 CNAs. -02/20/24 had 12 CNAs for 183 residents on the day shift, required at least 23 CNAs.	S 560		

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S 560	Continued From page 5 -02/21/24 had 14 CNAs for 183 residents on the day shift, required at least 23 CNAs. -02/22/24 had 15 CNAs for 183 residents on the day shift, required at least 23 CNAs. -02/23/24 had 16 CNAs for 183 residents on the day shift, required at least 23 CNAs. -02/24/24 had 13 CNAs for 182 residents on the day shift, required at least 23 CNAs. 8. For the week of Complaint staffing from 03/17/2024 to 03/23/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -03/17/24 had 13 CNAs for 177 residents on the day shift, required at least 22 CNAs. -03/18/24 had 12 CNAs for 177 residents on the day shift, required at least 22 CNAs. -03/19/24 had 12 CNAs for 177 residents on the day shift, required at least 22 CNAs. -03/20/24 had 15 CNAs for 177 residents on the day shift, required at least 22 CNAs. -03/21/24 had 17 CNAs for 174 residents on the day shift, required at least 22 CNAs. -03/22/24 had 16 CNAs for 174 residents on the day shift, required at least 22 CNAs. -03/23/24 had 12 CNAs for 174 residents on the day shift, required at least 22 CNAs. 9. For the week of Complaint staffing from 04/28/2024 to 05/04/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -04/28/24 had 15 CNAs for 181 residents on the day shift, required at least 23 CNAs. -04/29/24 had 11 CNAs for 181 residents on the day shift, required at least 23 CNAs. -04/30/24 had 13.5 CNAs for 181 residents on the day shift, required at least 23 CNAs.	S 560		

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S 560	Continued From page 6 -05/01/24 had 15 CNAs for 181 residents on the day shift, required at least 23 CNAs. -05/02/24 had 16 CNAs for 180 residents on the day shift, required at least 22 CNAs. -05/03/24 had 14.5 CNAs for 180 residents on the day shift, required at least 22 CNAs. -05/04/24 had 16 CNAs for 179 residents on the day shift, required at least 22 CNAs. 10. For the 2 weeks of staffing prior to survey from 05/26/2024 to 06/08/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -05/26/24 had 14 CNAs for 184 residents on the day shift, required at least 23 CNAs. -05/27/24 had 13 CNAs for 183 residents on the day shift, required at least 23 CNAs. -05/28/24 had 11 CNAs for 183 residents on the day shift, required at least 23 CNAs. -05/29/24 had 16 CNAs for 182 residents on the day shift, required at least 23 CNAs. -05/30/24 had 15 CNAs for 182 residents on the day shift, required at least 23 CNAs. -05/31/24 had 18 CNAs for 182 residents on the day shift, required at least 23 CNAs. -06/01/24 had 15 CNAs for 182 residents on the day shift, required at least 23 CNAs. -06/02/24 had 11 CNAs for 187 residents on the day shift, required at least 23 CNAs. -06/03/24 had 15 CNAs for 187 residents on the day shift, required at least 23 CNAs. -06/04/24 had 14 CNAs for 187 residents on the day shift, required at least 23 CNAs. -06/05/24 had 16 CNAs for 187 residents on the day shift, required at least 23 CNAs. -06/06/24 had 9 CNAs for 187 residents on the day shift, required at least 23 CNAs. -06/07/24 had 15.5 CNAs for 187 residents on the	S 560		

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S 560	Continued From page 7	S 560		

day shift, required at least 23 CNAs.
-06/08/24 had 14 CNAs for 189 residents on the day shift, required at least 24 CNAs.

On 06/13/2024 at 10:28 AM, during an interview with the surveyor, the Licensed Practical Nurse/Unit Manager (LPN/UM #4) when asked how staffing has been, replied, "So-so, it could be better some days." At that time the LPN/UM #4 provided the Dogwood Court Assignment Sheet for the 7-3 shift that revealed a census of 58 residents with four CNA's indicating a ratio of 1 CNA to 15 residents.

During an interview with the surveyor on 06/18/2024 at 10:24 AM, CNA #3 stated that he/she had 14 residents on his/her assignment. When asked, can you get all your work done on your 8 hours shift, CNA #3 stated, "If I move fast enough, we only have 2 CNAs on the unit."

On 06/13/2024 at 11:59 AM, during an interview with the surveyor, Resident #145 stated that he/she must wait a long time for assistance.

During an interview with the surveyor on 06/18/2024 at 11:03 AM, the Staffing Coordinator indicated that it is difficult to meet the staffing requirements. The Staffing Coordinator said that she was aware of the minimum staffing requirements for CNA's which is 1 to 8 residents for 7-3 shift, 1 to 10 residents for the 3-11 shift, and 1 to 14 for the 11-7 shift. We use agency staffing that is unreliable. We are not always able to meet staffing requirements.

During an interview with the surveyor on 06/18/24 at 12:14 PM, CNA #2 stated, "I typically have between 12-15 residents on day shift. Weekends

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S 560	Continued From page 8 are the same. Today, I have 3 Hoyer lifts which requires 2 CNA's to safely transfer; it is difficult to get assistance when staffing is limited. When asked, if he/she was able to complete all assignments during his/her shift, he/she replied, "no." On 06/19/24 at 12:33 PM in the presence of the survey team, the Director of Nursing (DON) stated the facility staffing is determined by the NJDOH requirements which are, 1:8 for 7-3 shift, 1:10 for 3-11 shift and 1:14 for 11-7 shift. The DON acknowledged that the facility was not meeting those requirements. A review of a policy provided by the facility titled, "Nursing Policy and Procedure," with a revision date of June 2020 and a review date of January 2024 revealed; "It is the policy of this facility to determine the appropriate staffing on a unit based on the census, acuity, shift and needs of the residents and staffing ratio required by the NJDOH.	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
315260 Y1	A. Building B. Wing Y2	8/1/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	600 PEMBERTON BROWN MILLS RD PEMBERTON, NJ 08068

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 F0658	Correction	ID Prefix F0725	Correction	ID Prefix F0755	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.35(a)(1)(2)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	07/26/2024	LSC	07/26/2024	LSC	07/26/2024
ID Prefix F0812	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	07/26/2024	LSC	07/26/2024	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?
6/20/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060302	A. Building B. Wing	8/1/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	600 PEMBERTON BROWN MILLS RD PEMBERTON, NJ 08068

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 07/26/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
6/20/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315260	A. BUILDING **01** B. WING _____	**06/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	**600 PEMBERTON BROWN MILLS RD** **PEMBERTON, NJ 08068**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 06/17/2024 and 06/18/2024 and Aspen Hills Healthcare Center was found to be in noncompliance 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 Occupancies. Aspen Hills Healthcare Center is a three story, Type II Protected building that was built in June 1985. The facility is divided into 19 smoke zones.	K 000		
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility documentation on 05/15/2024 and 05/16/2024, in the presence of facility Management, it was determined that the facility failed to ensure that 8 of 16 exit access (leading into stairwells) stairwell	K 311	I. All 8 (Birch Unit Stairway #5, #4, #3/Dogwood Unit Stairway #5, #4, #3/Oak Unit Stairway #5, #4) corridor exit access doors will have positive latch into their frames as required to maintain the exit	7/17/24

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

Electronically Signed | 07/02/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315260	A. BUILDING **01** B. WING _____	**06/20/2024**

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ASPEN HILLS HEALTHCARE CENTER	**600 PEMBERTON BROWN MILLS RD** **PEMBERTON, NJ 08068**

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K 311	Continued From page 1 doors tested, were capable of maintaining the 1-1/2 hour fire rated construction. This deficient practice was evidenced by the following, On 06/17/2024 (day one of survey) at approximately 8:44 AM, during the survey entrance, a request was made to the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. A review of the facility provided lay-out identified the facility is a three (3) story with Resident sleeping rooms and common areas of the 1st., 2nd. and 3rd. floors. There are seven (7) exit stairwells in the facility that Residents, Visitors and Staff could use in the event of an emergency. Starting at approximately 09:10 AM on 06/17/2024 and continued on 06/18/2024, in the presence of the facility's U.S. FOI a tour of the building was conducted. Along the two (2) day tour the surveyor inspected and conducted closure test of sixteen (16) exit access doors leading into exit stairway with the following results, On 06/17/2024: 1. At approximately 9:21 AM, during a closure test of the third (3rd.) floor "Birch Unit" stairway #5 corridor exit access door next to Resident room # NJ Ex Or when the U.S. FO entered the code to the key pad, the surveyor was able to push on the door and the door opened. When the fire alarm is activated the key pad disengages the door	K 311	stairwells 1 ¿ hour fire rated construction and to prevent fire, smoke, and poisonous gases to enter the exit stairwells in the event of a fire. No residents had negative outcomes related to the findings. II. All residents in the facility have the potential to be affected by this deficient practice. III. The Maintenance Department was re-educated about maintaining the 1 ¿ hour fire rated construction on stairway corridor exit access doors. IV. The Maintenance Director/Designee will monitor the stairway corridor exit access doors monthly x 4 to ensure positive latch into their frames as required to maintain the 1 ¿ hour fire rated construction. The Maintenance Director will report the findings quarterly x2 to the QA Committee, which will evaluate that the deficiency remains corrected and in compliance with regulatory requirements.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315260	A. BUILDING **01** B. WING _____	**06/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	**600 PEMBERTON BROWN MILLS RD** **PEMBERTON, NJ 08068**

(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
K 311	Continued From page 2 frame's keeper latching mechanism. The 1-1/2 hour fire rated door needs to positive latch into its frame as required to maintain the exit stairwells fire rated construction. 2. At approximately 9:27 AM, during a closure test of the third (3rd.) floor "Birch Unit" stairway #4 corridor exit access door next to Resident room #[NJ Ex Ord] when the [U.S. FC] entered the code to the key pad, the surveyor was able to push on the door and the door opened. When the fire alarm is activated the key pad disengages the door frame's keeper latching mechanism. The 1-1/2 hour fire rated door needs to positive latch into its frame as required to maintain the exit stairwells fire rated construction. 3. At approximately 9:40 AM, during a closure test of the third (3rd.) floor "Birch Unit" stairway #3 corridor exit access door next to Social room #3-E, when the [U.S. FC] entered the code to the key pad, the surveyor was able to push on the door and the door opened. When the fire alarm is activated the key pad disengages the door frame's keeper latching mechanism. The 1-1/2 hour fire rated door needs to positive latch into its frame as required to maintain the exit stairwells fire rated construction. 4. At approximately 12:51 PM, during a closure test of the second (2nd.) floor "Dogwood Unit" stairway #5 corridor exit access door next to Resident room #[NJ Ex Ord] when the [U.S. FC] entered the code to the key pad, the surveyor was able to push on the door and the door opened. When the fire alarm is activated the key pad disengages the door frame's keeper latching mechanism. The 1-1/2 hour fire rated door needs to positive latch into its frame as required to maintain the exit	K 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315260	A. BUILDING **01** B. WING _____	**06/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	**600 PEMBERTON BROWN MILLS RD** **PEMBERTON, NJ 08068**

(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
K 311	Continued From page 3 stairwells fire rated construction. 5. At approximately 1:01 PM, during a closure test of the second (2nd.) floor "Dogwood Unit" stairway #4 corridor exit access door next to Resident room #[NJ Ex Orc] when the [U.S. FC] entered the code to the key pad, the surveyor was able to push on the door and the door opened. When the fire alarm is activated the key pad disengages the door frame's keeper latching mechanism. The 1-1/2 hour fire rated door needs to positive latch into its frame as required to maintain the exit stairwells fire rated construction. 6. At approximately 1:17 PM, during a closure test of the second (2nd.) floor "Dogwood Unit" stairway #3 corridor exit access door next to Social room #2-E, when the [U.S. FC] entered the code to the key pad, the surveyor was able to push on the door and the door opened. When the fire alarm is activated the key pad disengages the door frame's keeper latching mechanism. The 1-1/2 hour fire rated door needs to positive latch into its frame as required to maintain the exit stairwells fire rated construction. On 06/18/2024: 7. At approximately 12:40 PM, during a closure test of the first (1st.) floor "OAK Unit" stairway #5 corridor exit access door next to Resident room #[NJ Ex Orc] when the [U.S. FC] entered the code to the key pad, the surveyor was able to push on the door and the door opened. When the fire alarm is activated the key pad disengages the door frame's keeper latching mechanism. The 1-1/2 hour fire rated door needs to positive latch into its frame as required to maintain the exit stairwells fire rated construction.	K 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315260	A. BUILDING **01** B. WING _____	**06/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	**600 PEMBERTON BROWN MILLS RD** **PEMBERTON, NJ 08068**

(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
K 311	Continued From page 4 8. At approximately 12:40 PM, during a closure test of the first (1st.) floor "OAK Unit" stairway #4 corridor exit access door next to Resident room #[NJ Ex Or] when the [U.S. FC] entered the code to the key pad, the surveyor was able to push on the door and the door opened. When the fire alarm is activated the key pad disengages the door frame's keeper latching mechanism. The 1-1/2 hour fire rated door needs to positive latch into its frame as required to maintain the exit stairwells fire rated construction. The stairwell doors would need to positive latch into their frames to maintain the 1-1/2 hour fire rated construction and to prevent fire, smoke and poisonous gases to enter the exit stairwells in the event of a fire. The [U.S. FC] confirmed the finding at the time of observations. The [U.S. FOIA (b) (6)] and [U.S. FC] were informed of the deficiency during the Life safety Code survey exit on 06/18/2024 at approximately 1:26 PM. Fire Safety Hazard.	K 311		
K 355 SS=D	NJAC 8:39- 31.2(e) Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced	K 355		7/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315260	A. BUILDING **01** B. WING _____	**06/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	**600 PEMBERTON BROWN MILLS RD** **PEMBERTON, NJ 08068**

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K 355	Continued From page 5 by: Based on observation and review of facility documentation on 06/17/2024 and 06/18/2024 in the presence of facility management, it was determined that the facility failed to: 1) Maintain 1 of 45 fire extinguishers in proper working condition, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and there after at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. - 7.3.1.2.1 Six-Year Internal Examination. Every 6 years, stored-pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable internal	K 355	I. On 6/18/2024, ABC-Type Fire extinguisher on the second floor SMART Unit near the Residents Lounge with pressure indicating needle in the RED discharge zone on the pressure gauge was replaced. No residents had negative outcomes related to these findings. II. All residents on the SMART Unit have the potential to be affected by this deficient practice. III. All fire extinguishers in the building were evaluated and found to be in proper working condition. IV. Maintenance Director/Designee will monitor all facility fire extinguishers monthly to ensure proper working condition. The Maintenance Director will report the findings quarterly x2 to the QA Committee, which will evaluate that the deficiency remains corrected and in compliance with regulatory requirements.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315260	A. BUILDING **01** B. WING _____	**06/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	**600 PEMBERTON BROWN MILLS RD** **PEMBERTON, NJ 08068**

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K 355	Continued From page 6 examination procedures as detailed in the manufacture's service manual and this standard. On 06/17/2024 (day one of survey) at approximately 8:44 AM, during the survey entrance, a request was made to the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. A review of the facility provided lay-out identified the facility is a three (3) story with Resident sleeping rooms and common areas of the 1st., 2nd. and 3rd. floors. Starting at approximately 09:10 AM on 06/17/2024 and continued on 06/18/2024, in the presence of the facility's U.S. FOI a tour of the building was conducted. Along the two (2) day tour the surveyor observed and inspected forty-five (45) portable fire extinguishers in various locations that were last annually inspected October 2023 with the following issues that were identified: 1) On 06/17/2024 at approximately 10:30 AM, during an inspection of the second floor "SMART Unit", the surveyor observed near the Residents lounge, One (1) "ABC-Type" fire extinguisher's pressure indicating needle was in the "RED" discharge zone on the pressure gauge on the fire extinguisher. At that time a request was made to the U.S. FC to replace the fire extinguisher. The U.S. FC complied with the request. The facility U.S. FC confirmed the finding at the time of observation. The U.S. FOIA (b) (6) and U.S. FC were informed of the	K 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315260	A. BUILDING **01** B. WING _____	**06/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 355	Continued From page 7 deficiency during the Life safety Code survey exit on 06/18/2024 at approximately 1:26 PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315260	A. Building 01 - MAIN BUILDING 01 B. Wing	8/1/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	600 PEMBERTON BROWN MILLS RD PEMBERTON, NJ 08068

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 Reg. # NFPA 101 LSC K0311	Correction Completed 07/17/2024	ID Prefix Reg. # NFPA 101 LSC K0355	Correction Completed 07/05/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
6/20/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO