STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315159	A. BUILDING _____ B. WING _____	C 07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	**425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS COMPLAINT#: NJ00175495 CENSUS: 279 SAMPLE SIZE: 4 THE FACILITY IS IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR, PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. .	F 000		

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

Electronically Signed | 08/12/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060411	A. BUILDING: _____ B. WING _____	C 07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

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S 000	Initial Comments COMPLAINT#: NJ00175495 CENSUS: 279 SAMPLE SIZE: 4 The facility was not in compliance with the standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 8 of 28 day shifts as follows: This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health	S 560	Elmwood Hills Healthcare Center S0560 07/16/2024 I. Corrective Action accomplished for Resident(s) affected: Director of Nursing/Designee meets daily and before weekends with staffing coordinator to review staff sufficiency. Staffing coordinator send daily emails with	8/12/24

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

Electronically Signed | 08/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060411	A. BUILDING: _____ B. WING _____	C 07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

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S 560	Continued From page 1 (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the 4 weeks of staffing from 6/30/2024 to 07/6/2024 and 07/7/2024 to 7/13/2024, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift and one direct care staff member to every 10 residents for the evening shifts as documented below: For the week of staffing from 06/30/2024 to 07/6/2024, the facility was deficient in CNA staffing for residents on 8 of 14 day shifts as follows: -06/30/24 had 28 CNAs for 272 residents on the day shift, required at least 34 CNAs. -07/01/24 had 32 CNAs for 272 residents on the day shift, required at least 34 CNAs.	S 560	the staffing number to the Administrator and Director of Nursing. II. Residents identified having the Potential to be affected and corrective action taken: All residents residing in the facility had the potential to be affected. A random sample of Twenty 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. Measures to be put in place to ensure the deficient practice will not recur: The Call Out Policy was reviewed by the facility administration and staff have been reeducated by the Facility Educator on the policy. Referral and Sign-on Bonuses are offered for both Licensed and Certified Nursing Staff. The Retention and Recruitment Coordinator and Nurse Educator meet at area Nursing and CNA Schools and host job fairs. Interviews are done on the spot. Staffing needs for the day are assessed daily and evaluated if the Nursing Management (Unit Managers, ADON, and Facility Educator) needs to assist with resident care. Staff recognition is done monthly, a monthly incentive is offered for staff that	

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	060411	A. BUILDING: _____ B. WING _____	C 07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

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S 560	Continued From page 2 -07/02/24 had 31 CNAs for 269 residents on the day shift, required at least 34 CNAs. -07/07/24 had 31 CNAs for 272 residents on the day shift, required at least 34 CNAs. -07/08/24 had 31 CNAs for 272 residents on the day shift, required at least 34 CNAs. -07/09/24 had 33 CNAs for 272 residents on the day shift, required at least 34 CNAs. -07/12/24 had 33 CNAs for 277 residents on the day shift, required at least 35 CNAs. -07/13/24 had 26 CNAs for 272 residents on the day shift, required at least 34 CNAs.	S 560	do not call out. Elmwood Hills established a recruitment and retention committee. Elmwood Hills hired a recruitment and retention employee. Elmwood Hills does weekly Orientation. Elmwood Hills uses multiple employment search engines and multiple social media platforms. Alert and Oriented residents will be interviewed regarding the timeliness of staff response when requesting help as part of their Quarterly care conference meetings. This date will be reported to 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. IV. Corrective Action will be monitored to ensure the deficient practice will not recur: The Director of Nursing (DON)/Designee will conduct daily Certified Nursing (CNA) staffing schedule audits for the next six months. The DON/designee will report audit findings to the Administrator for analysis, tracking and trending. The Administrator will report the findings of the Certified Nursing Assistant staffing audits to the Quality Assessment and Assurance (QAA) Committee for the next two quarters. The QAA committee will determine the need for any additional monitoring of Certified Nursing Assistant staffing after the 2nd quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060411	A. BUILDING: _____ B. WING _____	C 07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 3	S 560	V. Date of Compliance: 8/12/2024	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060411	A. Building B. Wing	8/13/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD HILLS HEALTHCARE CENTER LLC	425 WOODBURY-TURNERSVILLE ROAD BLACKWOOD, NJ 08012

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 08/12/2024	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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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	
7/16/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO