STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315297	A. BUILDING _____ B. WING _____	C 05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRIA AT THE FOUNTAINS	114 HAYES MILL ROAD ATCO, NJ 08004

(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#: NJ149005, NJ149006, NJ149159, NJ149310 CENSUS: 50 SAMPLE SIZE: 4 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: C#: NJ149310 Based on observation, interviews, medical record review, and review of other pertinent facility documents, it was determined that the facility failed to keep the call system within reach for a resident who was dependent on staff for transfers and able to use the call bell. The facility also failed to follow its policy titled "Answering the Call Light." This deficient practice was identified for 1 of 4 residents (Resident [redacted] and was evidenced by the following:	F 558	F558 483.10 (e) (3) Reasonable Accommodations Needs/Preferences The facility shall comply with applicable Federal, State and local laws, rules, and regulations. Corrective Action: Upon identification, Resident [redacted]'s call bell was immediately placed within reach per patient's preference	6/10/22

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

Electronically Signed | 06/06/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 558	Continued From page 1 During a tour on 5/18/2022 at 9:10 a.m., the Surveyor observed Resident [redacted] in his / her room, sitting up in bed, eating breakfast. The Surveyor observed the call bell was wrapped around the bed frame on the right side and not within the Resident's reach. The Surveyor asked Resident # [redacted] how he/she called for assistance. The Resident stated by using my call bell. The Surveyor then asked Resident # [redacted] to use his/her call bell to contact staff. The Resident then attempted to reach the call bell but could not do so. Resident [redacted] then stated to the Surveyor, "I am not able to reach the call bell." A review of the Electronic Medical Record was as follows: According to the Admission Record, Resident [redacted] was admitted to the facility on [redacted] with diagnoses that included [redacted]. A review of Resident [redacted] s Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that Resident [redacted] had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating the Resident has [redacted] required extensive assistance with bed mobility, personal hygiene, and locomotion on the unit and was totally dependent on two staff for transfers. During an interview on 5/18/2022 at 9:15 a.m., the Certified Nurse's Aide (CNA) assigned to Resident [redacted] stated the patient (Resident) is not usually in the bed for most of the day. The CNA further stated, "I forgot to adjust the Resident's	F 558	Identification of other residents or areas having the potential to be affected: Due to the nature of the deficiency, all residents have the potential to be affected by this practice. Measures put into Place: -Audit of call bell placement for residents completed: 5/18/22 -Education on call bell placement completed for staff including CNA assigned to Resident [redacted]. Completed: 5/23/22 Random Weekly Audits for call bell placement of 10% of the residents will be completed by the ADON or designee with results of audit to be submitted to the Quality Assurance Process Improvement Committee Meeting for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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ALLEGRIA AT THE FOUNTAINS	114 HAYES MILL ROAD ATCO, NJ 08004

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F 558	Continued From page 2 call bell; I got the Resident dressed and set up for breakfast. I should have put the call bell within reach of the Resident." During an interview on 5/18/2022 at 9:35 a.m., the Surveyor brought the above information to the attention of the Charge Nurse (CN), and she stated the call bell should always be within reach of the Resident. The CN further stated the CNA should ask the Resident where they prefer the call bell to be and make sure the Resident is able to reach the call bell to call for assistance as needed. During an interview on 5/18/2022 at 10:49 a.m., the Director of Nursing (DON) stated all call bells are expected to be within reach so that patients (residents) can access it to call for assistance. The DON said that the CNA should check the Resident's preference of where they prefer the call bell to be. The DON explained her expectation is for the call bell to always be within reach of the residents so that they can call for assistance. A review of the facility's policy titled "Answering the Call Light," with a revised date of 3/2017, included under "General Guidelines"#5 "when the Resident was in bed or confined to a chair, staff were to ensure the call light was within easy reach of the Resident." N.J.A.C.: 8:39-27.1 (a)	F 558		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		6/10/22

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F 656	Continued From page 3 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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F 656	Continued From page 4 section. This REQUIREMENT is not met as evidenced by: C#: NJ149310 Based on interviews, review of the medical record, and other pertinent facility documents on 5/17/2022 and 5/18/2022, it was determined that the facility failed to develop a comprehensive Care Plan (CP) as well as follow the facility's policy titled "Care Plan," for 1 of 4 residents (Resident [redacted]). This deficient practice was evidenced by the following: Review of the Electronic Medical records was as follows: According to the Admission Face Sheet Resident [redacted] was admitted to the facility on [redacted] with diagnoses which included but not limited to: [redacted]. A review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] indicated the resident had a score of [redacted] required extensive assistance with bed mobility, personal hygiene and locomotion on the unit and was totally dependent on two staff for transfers. Review of Resident [redacted] Physician's order Form dated [redacted] revealed the following treatment orders: Apply [redacted] to [redacted] at 8:00 p.m., do skin checks prior to applying daily, dated [redacted]. Apply [redacted] at 9:00 p.m., check skin prior to applying daily,	F 656	F656 483.21 (b) (1) Development/Implement Comprehensive Care Plan The facility shall comply with applicable Federal, State and local laws, rules, and regulations. Corrective Action: Resident [redacted] was transferred and admitted to an acute care setting Identification of other residents or areas having the potential to be affected: Due to the nature of the deficiency, all residents have the potential to be affected by this practice. Measures put into Place: -Upon Resident [redacted]'s return to facility, care plan was updated to reflect resident's current status inclusive of adaptive equipment orders -Resident care plans for those who have adaptive equipment orders will be audited by ADON/Designee to assure accuracy by 6/10/22 Random Weekly care plan audits of 10% of residents to be completed for those who have orders for adaptive equipment, by the ADON or designee with results of audit to be submitted to the Quality Assurance Process Improvement Committee Meeting for 6 months. Based on the results of these audits, a decision will be made regarding the need for	

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F 656	Continued From page 5 dated 3/28/2022. A review of Resident [redacted] CP dated on [redacted], revealed no Goals, Disciplines, or Interventions related to the Resident having a [redacted] and [redacted] or requiring any care or treatment for [redacted] or [redacted]. During an interview on 5/18/2022, at 2:00 p.m. the Charge Nurse (CN) stated Resident [redacted] doesn't have a CP for the orders mentioned". The CN informed the Surveyor that Resident [redacted] should have a CP for the devices. The CN further stated it was a Team effort to ensure that CP is initiated and revised once there is a new order for a resident. During an interview on 5/18/2022 at 10:49 a.m. the Director of Nurses (DON), the DON stated, no CP exists for Resident [redacted] The DON further said, the CP should be updated by the Team, which includes the CN, Unit Manager, Assistant DON. The DON stated her expectation will be for all new orders and interventions to be capture on the CP by the Team. Review of the facility policy titled "Care Plan -Interdisciplinary Team" last revised 09/2013, states" Our facility care planning /interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident." Under Policy Interpretation and Implementation, it states1. A comprehensive CP for each resident is developed within seven days of completion of the resident assessment (MDS).2. The CP is based on the resident's comprehensive assessment and is developed by a care planning /interdisciplinary team which	F 656	continued submission and reporting.	

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F 656	Continued From page 6 includes, but is not limited to the following personnel: a. the resident's attending physician; b. the registered nurse who has the responsibility of the resident; d. the social services worker responsible for the resident; f. therapists (speech, occupational, recreational, etc.), as applicable; h. the director of nursing (as applicable); k. Others as appropriate or necessary to meet the needs of the resident.	F 656		
F 658 SS=D	N.J.A.C.:8:39-11.2 (e)2 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: C#: NJ149006, NJ149159 Based on interviews, medical record reviews, and review of other pertinent facility documents on 5/17/2022 and 5/18/2022, it was determined that the facility failed to administer medications according to the Physician's Order, to maintain accurate medication administration documentation that indicated the medications were administered to the residents, failed to adhere to the acceptable standards of nursing practice and also failed to follow the facility's policy titled "Charting and Documentation." This deficient practice was identified for 2 of 4 residents (Resident [redacted] and Resident [redacted]) and was	F 658	F658 483.21 (b) (1) (i) Services Provided Meet Professional Standards The facility shall comply with applicable Federal, State and local laws, rules, and regulations. Corrective Action: Resident [redacted] is no longer at facility Resident [redacted] did not exhibit any adverse effects Identification of other residents or areas having the potential to be affected: Due to the nature of the deficiency, all residents have the potential to be affected	6/10/22

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F 658	Continued From page 7 evidenced by the following: 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 Registered Professional Nurse is defined as diagnosing and treating human response 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 restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: "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 otherwise legally authorized Physician or Dentist." Review of the Electronic Medical Records (EMRs) were as follows: 1. According to the "Admission Record (AR)," Resident [redacted] was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted]	F 658	by this practice. Measures put into Place: - Education to be provided by ADON or designee to licensed nurses on charting and documentation in the medical record by 6/10/22 Nursing will be educated on administering medications per MD order. Nursing will be educated to adhere to acceptable standards of nursing practice. -Audit of MARS to assure proper documentation by ADON or designee by 6/10/22 Weekly audits of the MAR will be completed 2x/week for 4 weeks then: Weekly audits of the MAR will be completed 1x/week for 4 weeks then: Random audits of the MAR, 10% of residents to be completed by ADMIN or designee with results of audit to be submitted to the Quality Assurance Process Improvement Committee Meeting for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 658	Continued From page 8	F 658		

According to the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] Resident [redacted] had a Brief Interview of Mental Status (BIMS) score of [redacted] indicating the resident had [redacted]. The MDS also showed the resident needed complete assistance with Activities of Daily Living (ADLs).

Review of the "Physician's Order Form (POF)" for Resident [redacted] dated [redacted] and [redacted] included the following Physician's Orders (PO's):

[redacted] (Concentrate) [redacted] (milligram) [redacted] ML (milliliter). Give [redacted] ml by mouth every 4 hours at 1:00 a.m., 5:00 a.m., 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. for [redacted] Management dated [redacted].

[redacted] MG Per [redacted] ML (PRN) as needed. Give [redacted] ml by mouth every 3 hours for [redacted] dated [redacted]

[redacted] Oral Tablet [redacted] MG. Give 1 tablet by mouth at bedtime for supplement, dated [redacted].

[redacted] Tablet 3.123 MG. Give 1 tablet by mouth every 12 hours for [redacted] Hold for [redacted] less than [redacted] dated [redacted].

[redacted]) Oral tablet [redacted] MG. Give 1 tablet by mouth five times per week at bedtime on [redacted], [redacted] and for [redacted] dated [redacted].

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F 658		F 658		

Continued From page 9

[redacted] by mouth three times daily for supplement dated [redacted].

Apply skin barrier cream to [redacted] and [redacted] day shift and evening shift for prevention dated [redacted].

Vital Signs Monitoring: Temperature Check every 12 hours dated [redacted]

Vital Signs Monitoring: [redacted] every 12 hours dated [redacted].

Vital Signs Monitoring: [redacted] Monitoring three times a week dated [redacted].

A review of the Controlled Drug Administration Record with a received date of [redacted] revealed that on [redacted] at 11:49 a.m., Resident [redacted] received [redacted] ml of [redacted] Solution instead of the [redacted] ml as ordered by the Physician.

A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated [redacted] and [redacted] for Resident [redacted] confirmed the aforementioned PO's were not administered because there was no documented evidence the staff gave the medication to the resident, as evidenced by the following:

[redacted]), Oral Tablet [redacted] MG. Give 1 tablet by mouth at bedtime for supplement; on [redacted] at 9:00 p.m. was blank.

[redacted] Tablet [redacted] MG Give 1 tablet by mouth every 12 hours for u[redacted] [redacted] Hold for [redacted]

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F 658	Continued From page 10 less than [redacted], on [redacted] 9:00 p.m. was blank. [redacted] tablet [redacted] MG. Give 1 tablet by mouth five times per week at bedtime on [redacted], and [redacted] for [redacted] on [redacted] at 9:00 p.m. was blank. [redacted] ounces by mouth three times daily for supplement on [redacted] at 5:00 p.m. was blank. Apply skin barrier cream to [redacted] and [redacted] day shift and evening shift for prevention on [redacted] at 7:00 a.m. was blank. Apply skin barrier cream to [redacted] and [redacted] day shift and evening shift for prevention on [redacted], [redacted], and [redacted] at 7:00 p.m. was blank. Vital Signs Monitoring: Temperature Check every 12 hours on [redacted] and [redacted] at 7:00 p.m. was blank. Vital Signs Monitoring: [redacted] every 12 hours on [redacted], [redacted], and [redacted] at 9:00 p.m. was blank. Vital Signs Monitoring: [redacted] Monitoring three times per week on [redacted] at 6:30 a.m. was blank. 2. According to the "AR," Resident [redacted] was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted]	F 658		

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F 658	Continued From page 11	F 658		

According to the MDS, dated [redacted] Resident [redacted] had a BIMS score of [redacted] indicating the resident was [redacted]. The MDS also showed the resident needed assistance with some ADLs: one-person physical assist for bed mobility (how the resident moves in bed) and two-person physical assistance for transfers from one surface to another.

Review of the "POF" for Resident [redacted] dated [redacted] included the following PO's:

[redacted]) Oral Tablet [redacted] MG Tablet, [redacted] tablet (s) by mouth every day at 2:00 p.m., for [redacted], dated [redacted].

[redacted] Oral Tablet [redacted] MG Tablet, 1 tablet(s) by mouth 4 times daily at 9:00 a.m., 2:00 p.m., 6:00 p.m., and 9:00 p.m. for [redacted], dated [redacted]. [redacted] Oral Tablet [redacted] MG, 1 tablet(s) by mouth twice daily for [redacted], dated [redacted].

[redacted] Solution [redacted], 1 [redacted] to [redacted] 4 times daily at 9:15 a.m., 1:15 p.m., 5:15 p.m., and 9:15 p.m. for [redacted], dated [redacted].

[redacted] Solution [redacted] 1 [redacted]) [redacted] twice daily to both [redacted] for [redacted], dated [redacted].

Vital Signs Monitoring, [redacted], daily, dated [redacted]

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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
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Vital Signs Monitoring, [redacted], day shift, and evening shift, dated [redacted]

A review of the [redacted] and [redacted] MAR for Resident [redacted] confirmed the aforementioned PO's were not administered because there was no documented evidence the staff gave the medication to the resident, as evidenced by the following:

[redacted] Oral Tablet [redacted] MG Tablet, [redacted] tablet(s) by mouth for [redacted] on [redacted] at 2:00 p.m. was blank.

[redacted] Oral Tablet [redacted] MG Tablet, 1 tablet(s) by mouth for [redacted] on [redacted] at 6 p.m., [redacted] at 9:00 p.m., [redacted] at 2:00 p.m. was blank.

[redacted] Oral Tablet [redacted] MG, 1 tablet(s) by mouth for [redacted] on [redacted] at 5:00 p.m. was blank.

[redacted] Solution for [redacted] on [redacted] and [redacted] at 5:15 p.m. was blank.

[redacted] Solution for [redacted] on [redacted] at 9:00 a.m. and on [redacted], [redacted], [redacted] at 5:00 p.m., was blank.

Vital Signs Monitoring, [redacted] daily, on [redacted] and [redacted], was blank.

Vital Signs Monitoring, [redacted], on [redacted] at 7:00 a.m., [redacted],

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	315297	A. BUILDING _____ B. WING _____	C 05/18/2022

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[redacted], and [redacted] at 7:00 p.m. was blank.

During an interview on 5/18/2021 at 11:03 a.m., the Charge Nurse (CN) stated the nurse who administered the [redacted] ml noted on the declining sheet or [redacted] was an agency nurse who no longer works for the facility. The CN stated, "I think the LPN (Licensed Practical Nurse) combined the order for [redacted] ml PO every 6 hours as needed for [redacted] along with the routine order of [redacted] ml for [redacted] together and administered it to the resident."

When the Surveyor asked what the blank spaces on the MAR and TAR meant, the CN stated, "the blanks will tell me the medication was not administered." The CN further stated that if a resident did not receive medication for some reason, the doctor (Physician) would be notified. The reasons for not administering the medications would be documented on the MAR and in the Progress Note (PN).

During an interview on 5/18/2022 at 11:15 a.m., the Surveyor asked the CN what should occur when there is a blank on the MAR or TAR; she stated that the nurse "should have written why it was not given."

During an interview on 5/18/2022 at 3:30 p.m., the Director of Nursing (DON) stated the blank spaces on the MARs and TARs meant there was an omission, meaning the medication was not administered. The Surveyor asked the DON about the [redacted] ml signed out for on the Narcotic declining sheet indicating the

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nurse did not administer the medication to Resident [redacted] according to the Physician's order. The DON stated at the time of the incident she was not the DON but was told the LPN working at the time combined Resident [redacted]'s ordered [redacted] ml for [redacted] along with the [redacted] ml ordered for [redacted] and administered both doses to the resident at the same time. According to the DON, the LPN no longer worked at the facility and was verbally counseled. The DON further stated the standard of care is to administer one dose at a time.

The Surveyor attempted to contact the LPN several times but received no response.

The Surveyor reviewed the EMRs, including the PNs; no documentation was noted for the medications and treatments administration or reasons for not administering the medications according to the Physician's order.

Review of facility's policy titled "Charting and Documentation" dated 7/2017 included the following: Under "Policy Statement": "All services provided to the resident, progress towards the care plan goals, or any changes in the resident's medical, physical, function or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Under "Policy Interpretation and Implementation" included: "The following information is to be documented in the resident medical record: ... b. Medications administered. Treatments and services performed;"

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F 658	Continued From page 15 N.J.A.C.: 8:39-27.1 (a)	F 658		

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	060419	A. BUILDING: _____ B. WING _____	C 05/18/2022

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S 000	Initial Comments COMPLAINT#: NJ149005, NJ149006, NJ149159, NJ149310 CENSUS: 50 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: C#: NJ149005, NJ149006, NJ149159, NJ149310 Based on facility document review on 5/17/2021 and 5/18/2022, it was determined that the facility	S 560	S560- 8:39-5.1 (a) Mandatory Access to Care The facility shall comply with applicable Federal, State and local laws, rules, and regulations.	6/10/22

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

Electronically Signed | 06/06/22

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S 560	Continued From page 1 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 28 of 28-day shifts for Certified Nurse's Aides (CNAs). This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with NJSA (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law PL 2020 c 112, codified as NJSA 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. For the week of 08/08/2021 to 08/14/2021, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 1 of 7 evening shifts as follows: On 08/08/21 had 3 CNAs for 58 residents on the day shift, required 8 CNAs. On 08/08/21 had 4 total staff for 58 residents on the evening shift, required 6 total staff.	S 560	1. Corrective Action: Efforts to hire facility staff will continue until there is adequate staff to serve all residents. Until that time, the facility will utilize staffing agencies to fill any open spots in the schedule and offer additional shifts to current staff. 2. Identification of other residents or areas having the potential to be affected: Due to the nature of the deficiency, all residents have the potential to be affected by this practice. 3. Measures put into Place: -Hiring and recruitment efforts including, pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to continue to be competitive in the marketplace. -Administrator or designee will document all recruitment efforts. 4. The Administrator or designee will review staffing schedules weekly to ensure adequate staffing for all shifts. The results of these reviews will be submitted to the Quality Assurance Process Improvement Committee Meeting for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting	

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S 560	Continued From page 2 On 08/09/21 had 6 CNAs for 57 residents on the day shift, required 8 CNAs. On 08/10/21 had 4 CNAs for 56 residents on the day shift, required 7 CNAs. On 08/11/21 had 5 CNAs for 56 residents on the day shift, required 7 CNAs. On 08/12/21 had 4 CNAs for 56 residents on the day shift, required 7 CNAs. On 08/13/21 had 4 CNAs for 56 residents on the day shift, required 7 CNAs. On 08/14/21 had 3 CNAs for 54 residents on the day shift, required 7 CNAs. For the 3 weeks of staffing from 09/26/2021 to 10/16/2021, the facility was deficient in CNA staffing for residents on 21 of 21-day shifts, deficient in total staff for residents on 1 of 21 evening shifts and deficient in CNAs to total staff on 1 of 21 evening shifts as follows: On 09/26/21 had 3 CNAs for 53 residents on the day shift, required 7 CNAs. On 09/27/21 had 2 CNAs for 53 residents on the day shift, required 7 CNAs. On 09/27/21 had 3 CNAs to 8 total staff on the evening shift, required 4 CNAs On 09/28/21 had 4 CNAs for 53 residents on the day shift, required 7 CNAs. On 09/29/21 had 2 CNAs for 53 residents on the day shift, required 7 CNAs. On 09/30/21 had 3 CNAs for 53 residents on the day shift, required 7 CNAs. On 10/01/21 had 4 CNAs for 53 residents on the day shift, required 7 CNAs. On 10/02/21 had 3 CNAs for 53 residents on the day shift, required 7 CNAs. On 10/03/21 had 3 CNAs for 53 residents on the day shift, required 7 CNAs. On 10/04/21 had 3 CNAs for 53 residents on the day shift, required 7 CNAs.	S 560		

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S 560	Continued From page 3 On 10/05/21 had 3 CNAs for 52 residents on the day shift, required 7 CNAs. On 10/06/21 had 4 CNAs for 51 residents on the day shift, required 7 CNAs. On 10/07/21 had 3 CNAs for 51 residents on the day shift, required 7 CNAs. On 10/08/21 had 3 CNAs for 51 residents on the day shift, required 7 CNAs. On 10/09/21 had 2 CNAs for 51 residents on the day shift, required 7 CNAs. On 10/10/21 had 3 CNAs for 51 residents on the day shift, required 7 CNAs. On 10/11/21 had 1 CNA for 52 residents on the day shift, required 7 CNAs. On 10/12/21 had 3 CNAs for 52 residents on the day shift, required 7 CNAs. On 10/13/21 had 2 CNAs for 52 residents on the day shift, required 7 CNAs. On 10/14/21 had 2 CNAs for 52 residents on the day shift, required 7 CNAs. On 10/15/21 had 5 CNAs for 51 residents on the day shift, required 7 CNAs. On 10/16/21 had 3 CNAs for 51 residents on the day shift, required 7 CNAs.	S 560		