

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

PRINTED: 03/27/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315126		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/28/2025	
NAME OF PROVIDER OR SUPPLIER BISHOP MCCARTHY CENTER FOR REHAB & HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1045 E CHESTNUT AVE VINELAND, NJ 08360			
(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 #: NJ00173757, NJ00181353, NJ00182768 Census: 170 Sample Size: 7 The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.			F 000			

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

TITLE

(X6) DATE

Electronically Signed

02/19/2025

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.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/28/2025
NAME OF PROVIDER OR SUPPLIER BISHOP MCCARTHY CENTER FOR REHAB & F		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 E CHESTNUT AVE VINELAND, NJ 08360		
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S 000	Initial Comments Complaint #: NJ00181353 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 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 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 20 day shifts. The deficient practice 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	S 560	1. Immediate action: No residents were affected. 2. Who was affected: All resident had potential to be affected by this deficient practice none were affected. 3. Corrective Actions: Measures have been taken by the Staffing Coord, Nursing Administration and Administrator and will continue to be put into place to ensure the deficient practice will not recur. These measures include Bonuses are offered for double shifts, extra shifts, weekend shifts.	2/24/25

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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/28/2025
NAME OF PROVIDER OR SUPPLIER BISHOP MCCARTHY CENTER FOR REHAB & F		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 E CHESTNUT AVE VINELAND, NJ 08360		
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S 560	<p>Continued From page 1</p> <p>nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified 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:</p> <p>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.</p> <p>1. For the week of Complaint staffing from 12/01/2024 to 12/07/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:</p> <p>-12/01/24 had 16 CNAs for 171 residents on the day shift, required at least 21 CNAs. -12/02/24 had 16 CNAs for 171 residents on the day shift, required at least 21 CNAs. -12/03/24 had 19 CNAs for 169 residents on the day shift, required at least 21 CNAs. -12/04/24 had 20 CNAs for 169 residents on the day shift, required at least 21 CNAs. -12/05/24 had 16 CNAs for 169 residents on the day shift, required at least 21 CNAs. -12/06/24 had 16 CNAs for 169 residents on the day shift, required at least 21 CNAs. -12/07/24 had 19 CNAs for 168 residents on the day shift, required at least 21 CNAs.</p>	S 560	<p>The staff has been re-educated immediately on the call out and lateness policy by Nursing Management and Nurse Educator. Facility employs a recruiter and posts openings on Indeed, APPLOI, and all applicants are met with upon receipt of application. Staffing Coord will call, text, email CNAs to take an open shift as needed. We offer sign on bonuses and Job Fairs. We contract with a variety of agencies, we offer referral bonuses, career ladder program, Shift differential on weekends, offer CNA Training classes free of charge.</p> <p>4. How this will be monitored: Corrective actions will be monitored by Staffing Coord daily. Director of Nursing/Designee will conduct weekly C.N.A. staffing schedule audits and will report audit findings to the Administrator. The Administrator/Designee will analyze and trend findings and report outcomes to the QAPI Committee quarterly with follow up to recommendations to ensure the deficient practice will not recur. This will be done weekly x4, monthly x3, quarterly x2.</p> <p>Completion Date: February, 24 2025</p>	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/28/2025
NAME OF PROVIDER OR SUPPLIER BISHOP MCCARTHY CENTER FOR REHAB & I			STREET ADDRESS, CITY, STATE, ZIP CODE 1045 E CHESTNUT AVE VINELAND, NJ 08360		
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S 560	Continued From page 2 2. For the 2 weeks of Complaint staffing from 01/05/2025 to 01/18/2025, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -01/05/25 had 18 CNAs for 162 residents on the day shift, required at least 20 CNAs. -01/06/25 had 15 CNAs for 161 residents on the day shift, required at least 20 CNAs. -01/07/25 had 13 CNAs for 161 residents on the day shift, required at least 20 CNAs. -01/08/25 had 16 CNAs for 161 residents on the day shift, required at least 20 CNAs. -01/09/25 had 17 CNAs for 161 residents on the day shift, required at least 20 CNAs. -01/10/25 had 15 CNAs for 161 residents on the day shift, required at least 20 CNAs. -01/11/25 had 18 CNAs for 166 residents on the day shift, required at least 21 CNAs. -01/12/25 had 15 CNAs for 166 residents on the day shift, required at least 21 CNAs. -01/13/25 had 18 CNAs for 166 residents on the day shift, required at least 21 CNAs. -01/14/25 had 20 CNAs for 169 residents on the day shift, required at least 21 CNAs. -01/15/25 had 19 CNAs for 169 residents on the day shift, required at least 21 CNAs. -01/16/25 had 17 CNAs for 169 residents on the day shift, required at least 21 CNAs. -01/18/25 had 18 CNAs for 167 residents on the day shift, required at least 21 CNAs.	S 560			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 060601	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 3/3/2025
NAME OF FACILITY BISHOP MCCARTHY CENTER FOR REHAB & HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1045 E CHESTNUT AVE VINELAND, NJ 08360	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/25/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 1/28/2025	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO
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