STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315126	A. BUILDING _____ B. WING _____	C 04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP MCCARTHY CENTER FOR REHAB & HEALTHCARE	**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: #NJ153434, #NJ154072 CENSUS: 123 SAMPLE SIZE: 3 THE FACILITY IS 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		

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

Electronically Signed | 06/01/2022

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
	060601	A. BUILDING: _____ B. WING _____	C 04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP MCCARTHY CENTER FOR REHAB & HEALTH	1045 E CHESTNUT AVE VINELAND, NJ 08360

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S 000	Initial Comments 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: COMPLAINT: #NJ153434, #NJ154072 Based on facility document review on 4/27/2022, 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 9 of 14 day shifts reviewed. This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health	S 560	S560 Mandatory Access to Care 1. Corrective actions immediately taken for any affected resident: a. DON and Staffing coordinator will evaluate staffing ratios for appropriate number of staff daily by shift in order to meet all staffing ratios II. Residents having the potential to be affected and action taken: a. The deficient practice has the potential to affect all residents residing in	5/27/22

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

Electronically Signed | 06/01/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060601	A. BUILDING: _____ B. WING _____	C 04/27/2022

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BISHOP MCCARTHY CENTER FOR REHAB & HEALTH	1045 E CHESTNUT AVE VINELAND, NJ 08360

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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. 1. For the week of 02/06/2022 to 02/12/2022, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows: On 02/06/22 had 15 CNAs for 133 residents on the day shift, required 17 CNAs. On 02/07/22 had 16 CNAs for 131 residents on the day shift, required 17 CNAs. On 02/10/22 had 15 CNAs for 125 residents on the day shift, required 16 CNAs. On 02/12/22 had 13 CNAs for 122 residents on the day shift, required 16 CNAs. 2. For the week of 04/10/2022 to 04/16/2022, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows:	S 560	the facility. No Residents were harmed. III. Measures developed to ensure the deficient practice will not recur: a. Administration/Nursing/Staffing Coordinator will meet daily to review the needs of the facility for the residents and be sure to schedule correct numbers of staff to safely care for the residents according to the Staffing ratios. b. Completed 6 week schedule with regular staff and calculate additional needs to fill in gaps as early as possible. c. An on call CNA list has been developed to cover any last minute callouts. d. Bonuses are offered as needed for hard to cover openings. Sign on and referral bonuses are offered as incentives for new and continued employment. e. The facility is recruiting for new employees with ads on INDEED and other related employment sites as well as scheduling a Job Fair to attract new staff. f. In an effort to make sure we have adequate staff to care for the residents, we will utilize Unit Managers, Supervisors ,staff educator, and other Nursing Management personnel to provide resident care. g. Agency staff are used to cover openings when they are available. IV. All newly developed corrective actions will be monitored to ensure the deficient practice will not recur: * The DON/Designee will conduct weekly C.N.A. staffing schedule audits x4 weeks, monthly x3, quarterly x2. * The DON/Designee will report audit	

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	060601	A. BUILDING: _____ B. WING _____	C 04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP MCCARTHY CENTER FOR REHAB & HEALTH	1045 E CHESTNUT AVE VINELAND, NJ 08360

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S 560	Continued From page 2 On 04/10/22 had 14 CNAs for 125 residents on the day shift, required 16 CNAs. On 04/12/22 had 15 CNAs for 125 residents on the day shift, required 16 CNAs. On 04/14/22 had 14 CNAs for 125 residents on the day shift, required 16 CNAs. On 04/15/22 had 14 CNAs for 125 residents on the day shift, required 16 CNAs. On 04/16/22 had 14 CNAs for 125 residents on the day shift, required 16 CNAs.	S 560	findings to the Administrator. The Administrator/Designee will review findings and report outcomes and recommendations to the QA Committee quarterly x2.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060601 Y1	A. Building B. Wing Y2	6/9/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP MCCARTHY CENTER FOR REHAB & HEALTHCARE	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 Reg. # 8:39-5.1(a) LSC	Correction Completed 06/02/2022	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
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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	
4/27/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO