STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060731	A. BUILDING: _____ B. WING _____	C 11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW COMMUNITY EXTENDED CARE FACILITY	266 S ORANGE AVE NEWARK, NJ 07103

(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) COMPLETE DATE
S 000	Initial Comments Complaint #: NJ148123 and #NJ148071 Census: 100 Sample Size: 16 TYPE OF SURVEY: Complaint Survey The facility is not in substantial compliance with all 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 provisions of 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 Intake: #NJ148123 Based on interviews, facility document review, and New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, it was determined the facility failed to maintain direct care staff-to-resident ratios as mandated by New Jersey State Law. This was evident for 14 out of 42 shifts reviewed. This had the potential to affect all residents.	S 560	1. RESIDENT AFFECTED BY THE DEFICIENT PRACTICE. No resident was affected by this deficient practice Cause of problem identification: The Administrator & the Director of Nursing including Human Resources reviewed facility staffing ratio and noticed	11/8/21

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

Electronically Signed — 11/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060731	A. BUILDING: _____ B. WING _____	C 11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW COMMUNITY EXTENDED CARE FACILITY	266 S ORANGE AVE NEWARK, NJ 07103

(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) COMPLETE DATE
S 560	Continued From page 1 Findings included: Reference: 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 nursing homes. The following ratio(s) were effective on 02/01/2021: One certified nurse aid 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 than half of all staff members shall be certified nurse aides (CNA), and each direct staff member shall be signed in to 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 certified nurse aide and perform certified nurse aide duties. 1. A review of the "Nurse Staffing Report," completed by the facility for the weeks of 10/17/2021 - 10/30/2021, revealed staff-to-resident ratios that did not meet the minimum requirements as listed below: 10/17/2021 had 7 CNAs for 99 residents on the day shift, required 13 CNAs. 10/18/2021 had 10 CNAs for 99 residents on the day shift, required 13 CNAs. 10/19/2021 had 11 CNAs for 99 residents on the	S 560	it did not meet the required daily staffing on a consistent basis. Our existing plan of recruitment did not meet the standard. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Action taken: The Administrator, Director of Nursing, and the Director of Human Resources in conjunction with the Chief Operating Officer and the Chief Executive Officer reviewed and revised our position control and recruitment methods. Completed: 11/08/21 2. IDENTIFYING OTHER RESIDENTS WHO COULD BE AFFECTED BY THE DEFICIENT PRACTICE. All department heads and Administrator will continue to use the Quality Assurance Daily Morning Meeting attendance log and the Nursing Home Resident Care Staffing Report tools already in place to monitor, track and review the plan for the department staffing needs. The report was presented to the Administrator, Human Resources, and Upper Management. Completed: 11/08/21 3. MEASURES OF SYSTEMIC CHANGES TO ENSURE THAT THE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060731	A. BUILDING: _____ B. WING _____	C 11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW COMMUNITY EXTENDED CARE FACILITY	266 S ORANGE AVE NEWARK, NJ 07103

(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) COMPLETE DATE
S 560	Continued From page 2 day shift, required 13 CNAs. 10/20/2021 had 7 CNAs for 99 residents on the day shift, required 13 CNAs. 10/21/2021 had 8 CNAs for 99 residents on the day shift, required 13 CNAs. 10/22/2021 had 9 CNAs for 99 residents on the day shift, required 13 CNAs. 10/23/2021 had 7 CNAs for 99 residents on the day shift, required 13 CNAs. 10/24/2021 had 7 CNAs for 99 residents on the day shift, required 13 CNAs. 10/25/2021 had 9 CNAs for 100 residents on the day shift, required 13 CNAs. 10/26/2021 had 9 CNAs for 99 residents on the day shift, required 13 CNAs. 10/27/2021 had 8 CNAs for 99 residents on the day shift, required 13 CNAs. 10/28/2021 had 9 CNAs for 99 residents on the day shift, required 13 CNAs. 10/29/2021 had 8 CNAs for 99 residents on the day shift, required 13 CNAs. 10/30/2021 had 8 CNAs for 98 residents on the day shift, required 13 CNAs. In an interview on 11/05/2021 at 2:45 PM, the Nursing Home Administrator (NHA) stated that they were aware of the mandate regarding staffing ratios. The facility currently had contracts with multiple staffing agencies in the area, but the agencies claimed they had no staff to send to the facility. The NHA stated job openings were posted on all of the job boards and the Director of Nursing (DON) attended neighborhood job fairs to recruit new staff. The NHA stated they had been cross training staff where appropriate and encouraged staff to bring on new people. The NHA stated the facility was a part of multiple neighborhood associations that brought in some new staff members. The NHA stated the facility had increased the CNA pay and offered as much	S 560	DEFICIENCIES WILL NOT OCCUR A) The facility policy on staffing was revised by the Administrator to include exploring other recruitment methods including Indeed, Local Newspaper, LinkedIn, Peerless, Company Website, N.J. Academy of Nutrition and Dietetics, Health Fairs and reaching out to local community organizations for staff recruits; increasing C.N.A. salary from $15 to $17 an hour; pay overtime for every hour worked outside of set hours; talking to staff and family members for help with recruitment; and, signed more contracts with additional staffing agencies. B) All Department Heads will review and submit their staffing monthly to Administrator for board review and this report will be presented during QAPI meeting quarterly times 1 year. Completed: 11/08/21 and ONGOING 4. MONITORING THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE. The Administrator and the Director of Nursing will continue to use the Quality Assurance Daily Morning Meeting attendance log and the Nursing Home Resident Care Staffing Report tools already in place and will present report to the board monthly and QAPI team quarterly to ensure continuous improvement. Completed: ONGOING	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060731	A. BUILDING: _____ B. WING _____	C 11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW COMMUNITY EXTENDED CARE FACILITY	266 S ORANGE AVE NEWARK, NJ 07103

(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) COMPLETE DATE
S 560	Continued From page 3 overtime as anyone wanted to work. The NHA stated recruiting staff for the building was difficult because of the area that the facility was located in. The NHA stated prospective staff said they did not want to come work there because they felt unsafe in the neighborhood. The NHA stated the facility was able to take CNA students, but the training programs in the area had no students to send them for training. The NHA stated the facility had the money and positions available but no persons to fill them.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060731 Y1	A. Building B. Wing Y2	12/1/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW COMMUNITY EXTENDED CARE FACILITY	266 S ORANGE AVE NEWARK, NJ 07103

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	11/08/2021	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 ☐	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?
11/5/2021	☐ YES ☐ NO