STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315038	A. BUILDING _____ B. WING _____	C 08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SUMMIT RIDGE	**20 SUMMIT STREET WEST ORANGE, NJ 07052**

(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 #: NJ00160705, NJ00164662, NJ00166717 Census: 141 Sample Size: 6 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 | 08/21/2024

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
	060739	A. BUILDING: _____ B. WING _____	C 08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SUMMIT RIDGE	20 SUMMIT STREET WEST ORANGE, NJ 07052

(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 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 facility document review on 08/08/2024, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey for 14 of 14 day shifts. This 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 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	S 560	Problem Identified Inadequate number of Certified Nursing Assistants 2. How the facility will identify other residents having the potential to be affected by the deficient practice? All the residents may be affected by the short staff as required by NJ DOH. 3. Systematic changes " The Administrator will in-service the Staffing Coordinator in reference to the state guideline S 560.	8/21/24

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

Electronically Signed | 08/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060739	A. BUILDING: _____ B. WING _____	C 08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SUMMIT RIDGE	20 SUMMIT STREET WEST ORANGE, NJ 07052

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S 560	Continued From page 1 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 than half of all staff members shall be CNAs, 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 CNA and perform CNA duties. The surveyor requested staffing for the weeks of 07/21/2024 to 07/27/2024 and 07/28/2024 to 08/03/2024. The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -07/21/24 had 16 CNAs for 145 residents on the day shift, required at least 18 CNAs. -07/22/24 had 17 CNAs for 145 residents on the day shift, required at least 18 CNAs. -07/23/24 had 17 CNAs for 145 residents on the day shift, required at least 18 CNAs. -07/24/24 had 17 CNAs for 145 residents on the day shift, required at least 18 CNAs. -07/25/24 had 17 CNAs for 145 residents on the day shift, required at least 18 CNAs. -07/26/24 had 16 CNAs for 145 residents on the day shift, required at least 18 CNAs. -07/27/24 had 17 CNAs for 145 residents on the day shift, required at least 18 CNAs.	S 560	" Human Resources will continue to post the vacancies in all 3 shifts. " Human Resources will schedule the Open House. " The Administrator will boost the rate during a call out coverage and on weekends. " The staffing agency will block a schedule for the open position to cover for the vacancies. 4. What Quality Assurance will be put in place? " The Staffing Coordinator will audit the staffing weekly for 4 weeks then monthly for 3 months. " The Staffing Coordinator will submit the audit report to the Quality Assurance Improvement Committee. 5. Person Responsible: Staffing Coordinator	

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COMPLETE CARE AT SUMMIT RIDGE	20 SUMMIT STREET WEST ORANGE, NJ 07052

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S 560	Continued From page 2 -07/28/24 had 16 CNAs for 148 residents on the day shift, required at least 18 CNAs. -07/29/24 had 16 CNAs for 148 residents on the day shift, required at least 18 CNAs. -07/30/24 had 17 CNAs for 147 residents on the day shift, required at least 18 CNAs. -07/31/24 had 16 CNAs for 143 residents on the day shift, required at least 18 CNAs. -08/01/24 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs. -08/02/24 had 16 CNAs for 141 residents on the day shift, required at least 18 CNAs. -08/03/24 had 14 CNAs for 141 residents on the day shift, required at least 18 CNAs.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060739 Y1	A. Building B. Wing Y2	8/26/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SUMMIT RIDGE	20 SUMMIT STREET WEST ORANGE, NJ 07052

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 08/21/2024	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 8/8/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?		☐ **YES** ☐ **NO**	