| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315246 | A. BUILDING _____ B. WING _____ | C 06/09/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PROMEDICA SKILLED NURSING & REHAB (WEST DEPTFORD)** | **550 JESSUP ROAD WEST DEPTFORD, NJ 08066** |

| (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<br><br>A Complaint Survey was conducted on behalf of the New Jersey Department of Health.<br><br>Complaint #: NJ00162610, NJ00163462, and NJ00163983<br><br>Survey Dates: 06/07/23 through 06/09/23<br><br>Survey Census: 128<br><br>Sample Size: 7<br><br>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 | 07/13/2023

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 |
|---|---|---|---|
| | 060807 | A. BUILDING: _____ B. WING _____ | C 06/09/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PROMEDICA SKILLED NURSING & REHAB (WEST DE | 550 JESSUP ROAD WEST DEPTFORD, NJ 08066 |

| (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<br><br>Complaint #: NJ00162610, NJ00163462, and NJ00163983<br><br>Survey Dates: 06/07/23 through 06/09/23<br><br>Survey Census: 128<br><br>Sample Size: 7:<br><br>The facility is 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<br><br>(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.<br><br>This REQUIREMENT is not met as evidenced by:<br>C#: NJ 00163983<br><br>Based on facility document review, it was determined that the facility failed to ensure staffing ratios were met to maintain the required | S 560 | It is the intent of this facility to provide minimum direct care staff to resident ratios.<br><br>A. No residents were affected by this practice. | 7/14/23 |

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

Electronically Signed | 07/13/23

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 060807 | A. BUILDING: _____ B. WING _____ | C 06/09/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PROMEDICA SKILLED NURSING & REHAB (WEST DE | 550 JESSUP ROAD WEST DEPTFORD, NJ 08066 |

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|---|---|---|---|---|
| S 560 | Continued From page 1<br>minimum staff-to-resident ratios as mandated by the state of New Jersey for 8 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents.<br><br>Findings include:<br><br>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 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:<br><br>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.<br><br>1. For the 2 weeks of staffing from 05/21/2023 to 06/03/2023, the facility was deficient in CNA staffing for residents on 8 of 14 day shifts as follows:<br><br>The facility was deficient in CNA staffing for residents on 8 of 14 day shifts as follows:<br><br>-05/21/23 had 15 CNAs for 127 residents | S 560 | B. Current residents have potential of being affected by this practice.<br><br>C. Nursing Home Administrator and/or designee will educate staffing co-ordinator, Director of Nursing and Unit Managers on maintaining minimum direct care staff to resident ratios.<br><br>D. Director of Nursing and/or designee will conduct random audits weekly x4 and then monthly x 2 of daily staffing sheets to evaluate whether certified nursing aids to resident ratios were met. Ongoing recruitment efforts continue to hire and retain certified nursing assistants. Facility established an inhouse Nurse Aide Training and Competency Evaluation Program to recruit and train future certified nursing assistants. Incentives are in place and enhanced for open shifts, new hires and referrals by employees. These audit results will be reviewed monthly x3 at the Quality Assessment and Assurance Committee with recommendations as appropriate. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| S 560 | Continued From page 2<br>on the day shift, required 16 CNAs.<br>-05/22/23 had 15 CNAs for 127 residents on the day shift, required 16 CNAs.<br>-05/23/23 had 14 CNAs for 127 residents on the day shift, required 16 CNAs.<br>-05/24/23 had 15 CNAs for 127 residents on the day shift, required 16 CNAs.<br>-05/25/23 had 15 CNAs for 127 residents on the day shift, required 16 CNAs.<br>-05/27/23 had 13 CNAs for 127 residents on the day shift, required 16 CNAs.<br>-05/28/23 had 15 CNAs for 128 residents on the day shift, required 16 CNAs.<br>-06/01/23 had 14 CNAs for 124 residents on the day shift, required 15 CNAs. | S 560 | | |

# STATE FORM: REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 060807 Y1 | A. Building<br>B. Wing Y2 | 7/14/2023 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PROMEDICA SKILLED NURSING & REHAB (WEST DEPTFORD) | 550 JESSUP ROAD<br>WEST DEPTFORD, NJ 08066 |

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 | 07/14/2023 | 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 |
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| 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? |
|---|---|
| 6/9/2023 | ☐ YES ☐ NO |