STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	**78 SLIKER ROAD CALIFON, NJ 07830**

(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 #: NJ00171484 Survey Dates: 03/04/2024 Census: 33 Sample Size: 2 THE FACILITY IS NOT 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		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00171484 Based on interviews, review of electronic medical records (EMR), and other pertinent facility documentation on 03/04/24, it was determined that the facility staff failed to maintain a complete and accurate medical record by having an incomplete [redacted] assessment for 1 of 2 residents (Resident #1) reviewed. This deficient practice was evidenced by the following: According to the Admission Record, Resident #1 was admitted to the facility with diagnoses which	F 641	1. How the corrective actions will be accomplished for those residents found to be affected by the deficient practice: The resident was immediately reassessed for [redacted]. Resident was [redacted]. The policy was reviewed with the resident on [redacted] was resident was able to NJ Exec Order 26.4b1 of the policy. 2. How the facility will identify the resident that will be potentially affected bu the same deficient practice:	4/1/24

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

Electronically Signed — 03/26/2024

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.

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F 641	Continued From page 1 included but were not limited to Ex Order 26.4B1 [redacted] Review of Resident #1's Ex Order 26.4B1 Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care revealed, that the resident did use Ex Order 26.4B1 Review of Resident #1's Ex Order 26.4B1 Quarterly MDS revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that the resident's Ex Order 26.4B1 [redacted] Review of Resident #1's 'NJ Exec Order 26.4b1 Safety Screen," (NJ Exec Order 26.4b1 Assessment), dated NJ Exec Order 26.4b1 at 11:42 A.M., revealed that the following sections were not completed: -Frequency -Safety -Resident need for adaptive equipment, and -IDTC [Interdisciplinary Team Conference] Decision. During an interview with the surveyor, on 03/04/24 at 2:20 P.M., the U.S. FOIA (b)(6) ([redacted] provided Resident #1's NJ Exec Order 26.4b1 Assessment. The U.S. FOIA (b) stated that the NJ Exec Order 26.4b1 Assessment had been completed by the facility's previous U.S. FOIA (b) and she was unsure as to why the screening was incomplete. The U.S. FOIA (b) further stated, "It should have been completed at that time." The surveyor requested for the U.S. FOIA (b) to please provide any additional information regarding the completion of a screening, and she stated that she would check.	F 641	All residents may have the potential to be affected by this deficient practice. 3. What are the measures and systemic changes the facility will put into place to ensure that the deficient practice will not recur: A. All residents were reviewed to identify who might be a potential smoker. B. IDC team will generate a list of smokers. C. All nursing staff were re-educated on smoking assessment for admission and readmission of residents. D. IDC team will review admission assessment to assure resident smoking assessment complete if resident is a smoker. 4. How the facility will monitor its corrective action to ensure that the deficient practice will not recur: Director of Nursing or designee will monitor smoking assessments for all new admissions weekly x 3 months. Results of audit will be discused at QAPI meeting.	

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F 641	Continued From page 2 During a follow-up interview on 03/04/24 at 3:14 P.M., the [U.S. FOIA (b)] stated that the facility had no additional documentation to provide to this surveyor regarding a completed [NJ Exec Order 26.4b] Assessment for Resident #1. NJAC 8:39-27.1(a)	F 641		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061003	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCEI	78 SLIKER ROAD CALIFON, NJ 07830

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S 000	Initial Comments 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 (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 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 18 of 28 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 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	S 560	1. There were no negative outcomes to any residents for the shifts identified as not meeting the NJ staffing requirements during the weeks of 1/28/2024-2/10/2024. The facility staffing coordinator was re-educated b y the Licensed Nursing home Administrator on the component of this regulation with an emphasis on CNA-to-resident ratio. 2. All residents have the potential to be affected by this deficient practice. 3. To increase CNA staffing jobs, we have posted to position on the Internet. We have contracted with a staffing agency. We have personally asked new recruits to	3/26/24

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

Electronically Signed | 03/26/24

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 1 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.) The surveyor requested staffing for the weeks of 01/28/2024 to 02/10/2024, the facility was deficient in CNA staffing for residents on 9 of 14 day shifts as follows: -01/28/24 had 3.3 CNAs for 31 residents on the day shift, required at least 4 CNAs. -01/29/24 had 3.8 CNAs for 31 residents on the day shift, required at least 4 CNAs. -01/30/24 had 3.6 CNAs for 31 residents on the day shift, required at least 4 CNAs. -02/01/24 had 3.3 CNAs for 31 residents on the day shift, required at least 4 CNAs. -02/02/24 had 3 CNAs for 32 residents on the day shift, required at least 4 CNAs. -02/03/24 had 3.1 CNAs for 30 residents on the day shift, required at least 4 CNAs. -02/04/24 had 3.9 CNAs for 30 residents on the day shift, required at least 4 CNAs. -02/07/24 had 3.9 CNAs for 30 residents on the day shift, required at least 4 CNAs.	S 560	contact other colleagues that might be interested in seeking new employment. 4. The Licensed Nursing Home Administrator or deisgnee will conduct and audit 2x weekly for 4 weeks, then monthly for two months. The findings of these audits will be reported ot the monthly QAPI meeting every 3 months.	

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S 560	Continued From page 2 -02/08/24 had 3.5 CNAs for 31 residents on the day shift, required at least 4 CNAs. 2. The surveyor requested staffing for the weeks of 02/18/2024 to 03/02/2024, the facility was deficient in CNA staffing for residents on 9 of 14 day shifts as follows: -02/18/24 had 3 CNAs for 31 residents on the day shift, required at least 4 CNAs. -02/20/24 had 3 CNAs for 31 residents on the day shift, required at least 4 CNAs. -02/21/24 had 3.7 CNAs for 31 residents on the day shift, required at least 4 CNAs. -02/22/24 had 3 CNAs for 31 residents on the day shift, required at least 4 CNAs. -02/24/24 had 3.1 CNAs for 31 residents on the day shift, required at least 4 CNAs. -02/25/24 had 3.1 CNAs for 31 residents on the day shift, required at least 4 CNAs. -02/27/24 had 3 CNAs for 33 residents on the day shift, required at least 4 CNAs. -03/01/24 had 3.9 CNAs for 33 residents on the day shift, required at least 4 CNAs. -03/02/24 had 1.9 CNAs for 33 residents on the day shift, required at least 4 CNAs.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315467 Y1	A. Building B. Wing Y2	4/18/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 F0641	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.20(g)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/01/2024	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?
3/4/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061003 Y1	A. Building B. Wing Y2	4/18/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

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	04/01/2024	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	
3/4/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO