STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315314	A. BUILDING _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR CARE AND REHABILITATION CENTER	**3325 HIGHWAY 35 HAZLET, NJ 07730**

(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 # NJ 184710 Census: 138 Sample Size: 4 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 | 05/22/2025

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
	061303	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR CARE AND REHABILITATION CENTE	3325 HIGHWAY 35 HAZLET, NJ 07730

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S 000	Initial Comments Complaint # NJ 184710 Census: 138 Sample Size: 4 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 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 21 day shifts. The deficient practice was evidenced by the following:	S 560	I. Immediate Action: 1. The Administrator and Director of Nursing met with the Staffing Coordinator to determine current staffing vacancies in the nursing department to ensure accuracy of facility needs. 2. The facility has reviewed current	5/30/25

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

Electronically Signed | 05/22/25

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	061303	A. BUILDING: _____ B. WING _____	C 04/30/2025

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S 560	Continued From page 1 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: 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 Complaint staffing from 03/02/2025 to 03/08/2025, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -03/02/25 had 15 CNAs for 145 residents on the day shift, required at least 18 CNAs. -03/03/25had 16 CNAs for 143 residents on the day shift, required at least 18 CNAs. -03/04/25 had 16 CNAs for 142 residents on the day shift, required at least 18 CNAs. -03/05/25 had 16 CNAs for 142 residents on the day shift, required at least 18 CNAs. -03/06/25 had 16 CNAs for 142 residents on the day shift, required at least 18 CNAs.	S 560	salaries in comparison to other facilities in the immediate area to ensure salary competitiveness within the community. 3. The facility works with a full-time recruiter whose responsibility is to recruit nurses and C.N.A.s. 4. The facility maintains contact with the company recruiters on a weekly basis and provide updates on current staffing needs. 5. Nursing Administration is available for interviews, hiring and training as needed to ensure all potential candidates are interviewed, evaluated and offered positions if appropriate. 6. The facility continues to offer incentives 7. The facility advertises on various platforms such as social media, posted flyers in various community establishments, colleges and schools. 8. Signs placed across facility property to enhance our recruitment efforts. II. Identification of Others: The facility respectfully submits that all residents may be affected by this practice. III. Systemic Changes 1. The Administrator, Director of Nursing, Human Resource Director and the Staffing Coordinator have reviewed the facility staffing ratios to ensure the facility meets the par levels. 1. Human Resource Director will complete exit interviews for all nursing employees who have vacated their positions in an attempt to address any	

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S 560	Continued From page 2 -03/07/25 had 16 CNAs for 140 residents on the day shift, required at least 17 CNAs. -03/08/25 had 16 CNAs for 139 residents on the day shift, required at least 17 CNAs. 2. For the 2 weeks of staffing prior to survey from 04/13/2025 to 04/26/2025, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -04/13/25 had 15 CNAs for 139 residents on the day shift, required at least 17 CNAs. -04/14/25 had 16 CNAs for 139 residents on the day shift, required at least 17 CNAs. -04/15/25 had 16 CNAs for 139 residents on the day shift, required at least 17 CNAs. -04/16/25 had 16 CNAs for 139 residents on the day shift, required at least 17 CNAs. -04/17/25 had 16 CNAs for 142 residents on the day shift, required at least 18 CNAs. -04/18/25 had 16 CNAs for 142 residents on the day shift, required at least 18 CNAs. -04/19/25 had 16 CNAs for 141 residents on the day shift, required at least 18 CNAs. -04/20/25 had 16 CNAs for 141 residents on the day shift, required at least 18 CNAs. -04/21/25 had 16 CNAs for 140 residents on the day shift, required at least 17 CNAs. -04/22/25 had 16 CNAs for 138 residents on the day shift, required at least 17 CNAs. -04/23/25 had 16 CNAs for 136 residents on the day shift, required at least 17 CNAs. -04/24/25 had 16 CNAs for 135 residents on the day shift, required at least 17 CNAs. -04/25/25 had 16 CNAs for 134 residents on the day shift, required at least 17 CNAs. -04/26/25 had 16 CNAs for 134 residents on the day shift, required at least 17 CNAs.	S 560	issues which could be affecting retention of employees. 2. Orientation frequency will be increased to ensure that all potential candidates for employment will have opportunities to complete the orientation soon after accepting a facility offer. IV. Quality Assurance 1. A tracking log will be maintained for all communication with recruiters, referrals, applicants, interviews, newly hired, orientation completion and success of recruitment efforts and will be reviewed monthly by Director of Nursing, Administrator and Human Resource Director. 2. All findings will be reviewed by the Quality Assurance Team at least quarterly and changes made as needed to improve facility ratios. V. Responsibility: Administrator, Director of Nursing, Staffing Coordinator and Human Resource Director. I. Immediate Action 1. The facility respectfully submits that staff to resident ratios was reviewed to maintain the required minimum direct care staff to- resident ratios as mandated by the state II. Identification of Others: 1. The facility respectfully submits that all residents may be affected by this practice. III. System Changes	

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S 560	Continued From page 3	S 560	1. Policy and Procedure for Minimal Staffing was reviewed and revised by Administrator and DON to include staffing ratio of C.N.A.s mandated by the state IV. Quality Assurance 1a) Audits will be completed by the HR to ensure that all staffing complies with staffing ratios. 1b) Audits will be done weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters. 1c) All negative findings will be brought to the DNS/Administrators attention immediately. 1d) The results of all audits will be brought to the QAPI committee quarterly x 4 quarters. V. Responsibility 1. Director of Nursing 2. Administrator 3.Human Resources and/or Staffing Coordinator	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061303 Y1	A. Building B. Wing Y2	5/23/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR CARE AND REHABILITATION CENTER	3325 HIGHWAY 35 HAZLET, NJ 07730

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 05/30/2025	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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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 4/30/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

 EVENT ID: OTS812