STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315286	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDBANK CENTER FOR REHABILITATION AND HEALING	**100 CHAPIN AVENUE , RED BANK, New Jersey, 07701**

(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
F0000	INITIAL COMMENTS Complaint #: 2567274 Census: 144 Sample Size: 7 THE FACILITY IS IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR, PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F0000		08/04/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061325	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDBANK CENTER FOR REHABILITATION AND HEALING	100 CHAPIN AVENUE , RED BANK, New Jersey, 07701

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S0000	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.	S0000		08/04/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Complaint #: 2567274 Based on interviews and review of facility documents on 7/24/2025, it was determined that the facility failed to ensure staffing ratios were met for 8 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents. Findings include: 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	S0560	1.The staffing coordinator was re inserviced on 8/4/2025 on the required minimum direct care staff to resident ratios. 2. All residents have the ability to be affected by this deficient practice. 3. The facility is working with in house as well as external recruiters to hire more staff. The facility has recently raised the nurses and CNA rates to better facilitate additional hiring of new staff. We also are contracted with staffing agencies to help fill in shifts where we are short staffed. Administrator and DON/designee will meet with staffing coordinator weeklyX4 weeks and then monthly X3 months, to go over staffing schedule to ensure compliance. 4. The findings of these audits will be reviewed by the Administrator/designee and presented at the quarterly QAPI meetings to determine frequeny of future audits.	08/04/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061325	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

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S0560	Continued from page 1 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. For the 2 weeks of staffing prior to complaint survey from 07/06/2025 to 07/19/2025, the facility was deficient in CNA staffing for residents on 8 of 14-day shifts as follows -07/06/25 had 16 CNAs for 142 residents on the day shift, required at least 18 CNAs. -07/07/25 had 17 CNAs for 142 residents on the day shift, required at least 18 CNAs. -07/08/25 had 16 CNAs for 142 residents on the day shift, required at least 18 CNAs. -07/11/25 had 17 CNAs for 142 residents on the day shift, required at least 18 CNAs. -07/13/25 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs. -07/14/25 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs. -07/18/25 had 17 CNAs for 144 residents on the day shift, required at least 18 CNAs. -07/19/25 had 17 CNAs for 144 residents on the day shift, required at least 18 CNAs.	S0560		