STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315397	A. BUILDING _____ B. WING _____	C 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	**2350 HOSPITAL ROAD ALLENWOOD, NJ 08720**

(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 #: NJ00144545, NJ00146272 Census: 127 Sample Size: 5 The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		

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

Electronically Signed | 09/01/2023

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
	061330	A. BUILDING: _____ B. WING _____	C 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	2350 HOSPITAL ROAD ALLENWOOD, NJ 08720

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S 000	Initial Comments Complaint #: NJ00144545, NJ00146272 Census: 127 Sample Size: 5 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 (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 interview and review of other facility documentation on 08/10/23 and 08/11/23, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratio for the day shift as mandated by the State of New Jersey. The facility was deficient in Certified Nursing Assistants (CNA) staffing for residents on 22 of 28 day shifts. This deficient practice had the potential to affect all residents. Findings include:	S 560	S560 1. There were no care concerns reported on the shifts that were identified. 2. All residents have the potential to be affected by this deficient practice. The Director of Nursing reviewed the last 30 days of the CNA (certified nursing aide) staffing report. The IDC (Inter disciplinary team) team reviewed facility grievance log and care and no care concerns were	8/23/23

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

Electronically Signed | 09/01/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061330	A. BUILDING: _____ B. WING _____	C 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	2350 HOSPITAL ROAD ALLENWOOD, NJ 08720

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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 at 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 (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) 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 CNA and shall perform nurse aide duties: and One (1) 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. As per the "Nurse Staffing Report" completed by the facility for the week of 04/04/21 through 04/10/21, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -04/04/21 had 12 CNAs for 110 residents on the day shift, required at least 14 CNAs. -04/06/21 had 13 CNAs for 110 residents on the day shift, required at least 14 CNAs. -04/07/21 had 12 CNAs for 110 residents on the day shift, required at least 14 CNAs. -04/09/21 had 12 CNAs for 111 residents on the day shift, required at least 14 CNAs.	S 560	identified. 3. Facility Staffing Coordinator was in service on 08/11/2023 on the requirements for proper CNA (certified nursing aide) staffing and ratios and the need to review and address the staffing needs daily to meet the state requirements. Recruitment efforts are in place to assist the facility in hiring staff. CNA (certified nursing aide) receive sign on bonuses, referral bonuses and tuition aid for CNA (certified nursing aide) classes at times. The facility also has contracts with staffing agencies as well as paid advertisements to help with our recruitment effort. The Staffing Coordinator or designee also reviews staff attendance records to ensure that excessive callouts are addressed. 4. The Facility Administrator, Director of Nursing and the Staffing Coordinator will conduct weekly meetings x4 then monthly x 6 to review staffing schedules, upcoming needs, and the efficacy of the systems in place to fill the facility needs. The findings will be reported at the quarterly Quality Assurance Committee meetings x3 quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061330	A. BUILDING: _____ B. WING _____	C 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	2350 HOSPITAL ROAD ALLENWOOD, NJ 08720

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S 560	Continued From page 2 -04/10/21 had 12 CNAs for 111 residents on the day shift, required at least 14 CNAs. 2. As per the "Nurse Staffing Report" completed by the facility for the week of 05/30/21 to 06/05/21, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows: -05/30/21 had 12 CNAs for 115 residents on the day shift, required at least 14 CNAs. -06/04/21 had 12 CNAs for 112 residents on the day shift, required at least 14 CNAs. -06/05/21 had 12 CNAs for 112 residents on the day shift, required at least 14 CNAs. 3. As per the "Nurse Staffing Report" completed by the facility for the weeks of 07/23/23 to 08/05/23, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -07/23/23 had 14 CNAs for 125 residents on the day shift, required at least 16 CNAs. -07/24/23 had 14 CNAs for 125 residents on the day shift, required at least 16 CNAs. -07/25/23 had 14 CNAs for 122 residents on the day shift, required at least 15 CNAs. -07/26/23 had 14 CNAs for 122 residents on the day shift, required at least 15 CNAs. -07/27/23 had 14 CNAs for 122 residents on the day shift, required at least 15 CNAs. -07/28/23 had 14 CNAs for 122 residents on the day shift, required at least 15 CNAs. -07/29/23 had 14 CNAs for 122 residents on the day shift, required at least 15 CNAs. -07/30/23 had 14 CNAs for 126 residents on the day shift, required at least 16 CNAs. -07/31/23 had 14 CNAs for 126 residents on the day shift, required at least 16 CNAs. -08/01/23 had 14 CNAs for 126 residents on the day shift, required at least 16 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061330	A. BUILDING: _____ B. WING _____	C 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 3 -08/02/23 had 14 CNAs for 126 residents on the day shift, required at least 16 CNAs. -08/03/23 had 14 CNAs for 126 residents on the day shift, required at least 16 CNAs. -08/04/23 had 14 CNAs for 126 residents on the day shift, required at least 16 CNAs. -08/05/23 had 14 CNAs for 128 residents on the day shift, required at least 16 CNAs. On 08/11/23 at 3:30 PM, the surveyor interviewed the Director of Nursing and Regional Licensed Nursing Home Administrator (LNHA). The Regional LNHA stated that they were aware of the staffing regulations and that the facility was had ongoing efforts to retain current staff and to recruit new staff.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061330 Y1	A. Building B. Wing Y2	9/8/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT WALL	2350 HOSPITAL ROAD ALLENWOOD, NJ 08720

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	08/23/2023	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
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	
8/11/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO