

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

PRINTED: 07/31/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/20/2025
NAME OF PROVIDER OR SUPPLIER CONCORD HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 963 OCEAN AVE LAKWOOD, NJ 08701		
(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	<p>INITIAL COMMENTS</p> <p>Complaint #: NJ181716</p> <p>Sample Size: 3</p> <p>Census: 91</p> <p>Survey Date: 03/20/2025</p> <p>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.</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/31/2025

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.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/20/2025
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NAME OF PROVIDER OR SUPPLIER CONCORD HEALTHCARE & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 963 OCEAN AVE LAKEWOOD, NJ 08701
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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 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ181716 Based on interviews and review of facility documents on 03/20/2025, it was determined that the facility failed to ensure staffing ratios were met for 1 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	S 560	S560 Staffing 1. No negative outcomes have been reported to the facility from this deficit practice. 2. All residents have the potential to be affected by this practice. 3. It is the intent of Concord Healthcare and Rehabilitation Center to maintain staffing requirement in compliance with all state and federal regulation. Contracts with staffing agencies have been secured to supplement facility staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, shift differentials and	3/31/25

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S 560	<p>Continued From page 1</p> <p>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:</p> <p>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.</p> <p>For the 2 weeks of AAS-11 staffing, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows:</p> <p>On 03/10/25 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs.</p>	S 560	<p>referral bonuses are being utilized to become more competitive in the marketplace. Wage increases for CNAs went into effect January 1st, 2025. Since January 1st, 2025, the facility has seen improvement with staffing requirements.</p> <p>4. The Administrator or Designee will review staffing schedules weekly to ensure adequate staffing for all shifts. The results of these reviews will be submitted to the QAPI committee through June 2025. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. QAPI is held on a quarterly basis.</p>	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 061519	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 4/8/2025	Y3
NAME OF FACILITY CONCORD HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 963 OCEAN AVE LAKEWOOD, NJ 08701		

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	03/31/2025	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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 3/20/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		