STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. BUILDING _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WHITING	**3000 HILLTOP ROAD WHITING, NJ 08759**

(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 #:NJ171799 Census: 148 Sample Size: 3 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 | 03/14/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061534	A. BUILDING: _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WHITING	3000 HILLTOP ROAD WHITING, NJ 08759

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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 deficieny 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: Complaint #: NJ171799 Based on interviews and review of facility documents on 3/5/2024, it was determined that the facility failed to ensure staffing ratios were met for residents on 14 of 14-day shifts and deficient in total staff for residents on 3 of 14 overnight 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	1. There were no care issues reported on the shifts that were identified. 2. All residents have the potential to be affected by this practice. The Director of Nursing/designee reviewed the last 30 days of CNA staffing schedules. The Interdisciplinary team reviewed all the care conference meetings had with residents and family members during this period including a review of the grievance logs and no care issues were identified. 3. The Administrator in serviced the new Staffing Coordinator regarding the requirements of S560 to ensure CNA staffing needs are reviewed daily and	3/14/24

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COMPLETE CARE AT WHITING	3000 HILLTOP ROAD WHITING, NJ 08759

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S 560	Continued From page 1 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. The facility was deficient in CNA staffing for residents on 14 of 14-day shifts and deficient in total staff for residents on 3 of 14 overnight shifts as follows: ON 02/11/24 had 11 CNAs for 163 residents on the day shift, required at least 20 CNAs. On 02/12/24 had 18 CNAs for 163 residents on the day shift, required at least 20 CNAs. On 02/12/24 had 11 total staff for 163 residents on the overnight shift, required at least 12 total staff. On 02/13/24 had 16 CNAs for 163 residents on the day shift, required at least 20 CNAs. On 02/14/24 had 14 CNAs for 163 residents on the day shift, required at least 20 CNAs. On 02/14/24 had 11 total staff for 163 residents on the overnight shift, required at least 12 total staff. On 02/15/24 had 18 CNAs for 160 residents on the day shift, required at least 20 CNAs. On 02/16/24 had 19 CNAs for 159 residents on	S 560	addressed as needed to meet the staffing requirements. We continued to expand our recruitment efforts to assist the facility in bringing on new CNA's. We increased sign on bonuses and the referral bonuses offered. We now offer reimbursement for transportation expenses from certain locations. In addition the facility has been expanding our contracts with agencies to assist in recruiting CNA's. 4. The Administrator/Designee will meet weekly for 3 months with the staffing coordinator to review staffing schedules, needs and the efficiency of the recruiting systems in place. The The findings of these audits will be presented to the Quality Assurance Performance Committee's monthly meeting for 3 months. Results from these meetings will determine the need for continued audits.	

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S 560	Continued From page 2 the day shift, required at least 20 CNAs. On 02/17/24 had 15 CNAs for 159 residents on the day shift, required at least 20 CNAs. ON 02/18/24 had 12 CNAs for 159 residents on the day shift, required at least 20 CNAs. On 02/19/24 had 15 CNAs for 159 residents on the day shift, required at least 20 CNAs. On 02/20/24 had 13 CNAs for 157 residents on the day shift, required at least 20 CNAs. On 02/21/24 had 14 CNAs for 157 residents on the day shift, required at least 20 CNAs. On 02/22/24 had 16 CNAs for 157 residents on the day shift, required at least 20 CNAs. On 02/23/24 had 15 CNAs for 157 residents on the day shift, required at least 20 CNAs. On 02/23/24 had 9 total staff for 157 residents on the overnight shift, required at least 11 total staff. On 02/24/24 had 11 CNAs for 159 residents on the day shift, required at least 20 CNAs.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061534 Y1	A. Building B. Wing Y2	5/10/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WHITING	3000 HILLTOP ROAD WHITING, NJ 08759

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 03/14/2024	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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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	
3/5/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO