STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315367	A. BUILDING _____ B. WING _____	C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HERITAGE NURSING AND REHABILITATION CENTER	**380 DEMOTT LANE SOMERSET, NJ 08873**

(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 181913 Census: 192 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 | 02/04/2025

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 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
	061801	A. BUILDING: _____ B. WING _____	C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HERITAGE NURSING AND REHABIL	380 DEMOTT LANE SOMERSET, NJ 08873

(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) COMPLETE DATE
S 000	Initial Comments Complaint #: NJ00181913 Census: 192 Sample size: 4 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 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00181913 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 of 21 day shifts. The deficient practice was evidenced by the following:	S 560	1. Immediate movement of ancillary staff to units to assist with tasks: call bells, trays, phones, transport, to enable nursing staff to concentrate on patient care. 2.All residents have the potential to be affected.	2/4/25

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

Electronically Signed — 02/04/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061801	A. BUILDING: _____ B. WING _____	C 01/14/2025

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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 12/15/2024 to 12/21/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -12/15/24 had 19 CNAs for 185 residents on the day shift, required at least 23 CNAs. -12/16/24 had 20 CNAs for 184 residents on the day shift, required at least 23 CNAs. -12/17/24 had 20 CNAs for 184 residents on the day shift, required at least 23 CNAs. -12/18/24 had 20 CNAs for 181 residents on the day shift, required at least 23 CNAs. -12/19/24 had 20 CNAs for 181 residents on the day shift, required at least 23 CNAs. -12/20/24 had 20 CNAs for 181 residents on the	S 560	3.a. Administrator/Designee will review staffing and utilize available resources to ensure mandatory staffing is maintained. As needs change, immediate response by adjusting schedules and use of other departments to answer phones, call bells, deliver trays and transport. b. Administration to focus on mandatory staffing and hiring by: -Utilizing agency to increase staffing numbers -Ads placed on several job sites and attendance to job fairs -Facility to offer incentives, increase rates, bonuses and food allowance -Facility to utilize other departments to answer call bells, pass trays, answer phones and transport residents 4.the administrator will review staffing ratios and acuities monthly for 6 months to determine the efficacy of the interventions and adjust as needed, results will be submitted. to QA for review and discussion. -the administrator will also review the use of resources, agency, ancillary staff and overtime to determine the effectiveness of ads, incentives, rate increases, bonuses and food allowance monthly for 6 months and make changes as needed, results willnbe submitted to QA quarterly for review and discussion.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061801	A. BUILDING: _____ B. WING _____	C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HERITAGE NURSING AND REHABIL	380 DEMOTT LANE SOMERSET, NJ 08873

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S 560	Continued From page 2	S 560		

day shift, required at least 23 CNAs.
-12/21/24 had 20 CNAs for 181 residents on the day shift, required at least 23 CNAs.

2. For the 2 weeks of staffing prior to survey from 12/29/2024 to 01/11/2025, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:

-12/29/24 had 19 CNAs for 181 residents on the day shift, required at least 23 CNAs.
-12/30/24 had 20 CNAs for 181 residents on the day shift, required at least 23 CNAs.
-12/31/24 had 20 CNAs for 181 residents on the day shift, required at least 23 CNAs.
-01/01/25 had 20 CNAs for 181 residents on the day shift, required at least 23 CNAs.
-01/02/25 had 20 CNAs for 184 residents on the day shift, required at least 23 CNAs.
-01/03/25 had 20 CNAs for 184 residents on the day shift, required at least 23 CNAs.
-01/04/25 had 20 CNAs for 184 residents on the day shift, required at least 23 CNAs.

-01/05/25 had 20 CNAs for 188 residents on the day shift, required at least 23 CNAs.
-01/06/25 had 20 CNAs for 188 residents on the day shift, required at least 23 CNAs.
-01/07/25 had 20 CNAs for 188 residents on the day shift, required at least 23 CNAs.
-01/08/25 had 20 CNAs for 188 residents on the day shift, required at least 23 CNAs.
-01/09/25 had 20 CNAs for 195 residents on the day shift, required at least 24 CNAs.
-01/10/25 had 20 CNAs for 194 residents on the day shift, required at least 24 CNAs.
-01/11/25 had 19 CNAs for 190 residents on the day shift, required at least 24 CNAs.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061801 Y1	A. Building B. Wing Y2	2/25/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HERITAGE NURSING AND REHABILITATION CENTER	380 DEMOTT LANE SOMERSET, NJ 08873

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	02/04/2025	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 ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/14/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO