STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315137	A. BUILDING _____ B. WING _____	C 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARN HILL CARE AND REHAB CENTER	**249 HIGH STREET NEWTON, NJ 07860**

(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 #: NJ172653 Census: 140 Sample Size: 3 THE FACILITY IS NOT 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		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		4/22/24

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

Electronically Signed | 04/22/2024

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.

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F 656	Continued From page 1 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Complaint # NJ172653 Based on interviews, medical record review, and review of other pertinent facility documents on 04/08/2024 and 04/09/2024, it was determined that the facility failed to develop and implement a NJ Exec. Order 26:4.b.1) Care Plan (CP) for a resident (Resident #2) NJ ex order 26.4b1 [redacted] and failed to follow its policy titled "Care Plans, Comprehensive Person-Centered." This deficient practice was identified for 1 of 3 residents reviewed for CP and was evidenced by the following:	F 656	1. All nurses have received in-service training on developing and implementing compresive person-centered care planning. 2. Individual residents have the potential to be affected by the failure to develop and implement a comprehensive person-centered care plan. 3. The facility determined that the root cause of this deficient practice was due to the need for enhanced checks and audits. For this reason, the facility has put additional measures in place to ensure care plans are properly developed and	

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F 656	Continued From page 2 Review of the Electronic Medical Record (EMR) was as follows: According to the Admission Record (AR), Resident #2 was NJ ex order 26.4b1 with diagnoses which included but were not limited to NJ ex order 26.4b1 A review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ ex order 26.4b1, Resident #2 had a Brief Interview of Mental Status (BIMS) score of [redacted], which indicated the resident was NJ ex order 26.4b1. The MDS also indicated the NJ ex order 26.4b1 A review of Resident #2's [redacted] initiated on NJ ex order 26.4b1 did not reveal evidence of a N[redacted]. During an interview on 04/09/2024 at 12:38 p.m. the Surveyor asked if Resident #2 should have had a NJ ex order 26.4b1, The Licensed Practical Nurse (LPN) stated, "Yes," there should have been a NJ ex order 26.4b1 upon admission for Resident #2's NJ ex order 26.4b1. She further stated the importance of the CP is to show how a resident care is to be provided and how the interventions should be followed. A review of Resident #2's Progress Notes (PNs) dated NJ ex order 26.4b1 revealed documentation of the resident's [redacted] status been maintained. During an interview on 04/08/2024 at 1:23 p.m., the Certified Nursing Aide (CNA) assigned to	F 656	implemented upon admission into the facility and updated as needed. The unit managers will conduct daily care plan audits of new admissions. The Assistant Director of Nursing will conduct an audit of care plans every other day to ensure that care plans are in place for all new admissions for 2 months. 4. To monitor this plan of correction, the facility's Director of Nursing will conduct a weekly audit, for two months, of all care plans, to ensure adherence to the facility's policies and procedures on developing and implementing comprehensive person-centered care plans. The QAPI committee will review the audit and checks monthly to ensure that the corrective measures are working.	

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F 656	Continued From page 3	F 656		

Resident #2 stated she was aware of Resident #2's [NJ ex orde] status from the shift-to-shift report given by Resident #2's Nurses. She further revealed Resident #2 had a [NJ Exec. Order 26] [a system the facility used to indicate [NJ ex order 2] status for residents] on his/her room door, name identification bracelet and at the head of their bed which was an indication of their [NJ ex orde] status.

During an interview on 04/09/2024 at 12:51 p.m., the Assistant Director of Nursing (ADON) stated, "The purpose of the [NJ ex o] is to ensure continuity of care for the residents and that the proper care is provided to the residents." She stated that the [NJ ex order 26.4b1] should have been initiated upon admission. When presented with Resident #2's [NJ ex o], the ADON stated, "I don't see a [NJ ex order 26.4b1].

A review of the facility's "Care Plans, Comprehensive, Person-Centered" revised 10/2022 under "Policy Statement": A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs developed and implemented for each resident.

N.JA.C.: 8:39-11.2(d)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061903	A. BUILDING: _____ B. WING _____	C 04/09/2024

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BARN HILL CARE AND REHAB CENTER	249 HIGH STREET NEWTON, NJ 07860

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S 000	Initial Comments Complaint#: NJ172653 Census: 140 Sample: 3 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 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ172653 Based on interviews and review of facility documents on 4/8/2024 and 4/9/2024, it was determined that the facility failed to ensure staffing ratios were met for 14 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents. Findings include:	S 560	1. No residents were affected by this deficient practice. 2. All residents have the potential of being affected by this deficient practice. 3. DON/Designee in-serviced staffing coordinator on staffing levels. The facility is actively recruiting for CNAs and we have a dedicated corporate	4/22/24

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

Electronically Signed | 04/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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. The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: On 03/17/24 had 9 CNAs for 141 residents on the day shift, required at least 18 CNAs. On 03/18/24 had 12 CNAs for 138 residents on the day shift, required at least 17 CNAs. On 03/19/24 had 16 CNAs for 138 residents on the day shift, required at least 17 CNAs. On 03/20/24 had 14.5 CNAs for 138 residents on the day shift, required at least 17 CNAs. On 03/21/24 had 16.5 CNAs for 138 residents on the day shift, required at least 17 CNAs. On 03/22/24 had 12.5 CNAs for 138 residents on the day shift, required at least 17 CNAs. On 03/23/24 had 14 CNAs for 137 residents on	S 560	recruiter leading the charge. The facility has advertised open jobs through online recruitment platforms as well as traditional recruitment agencies. The facility has conducted job fairs and has contracts with nursing staffing agencies. The facility also entered into an agreement with a CNA training school, ACE Healthacare and Training Institute. 4. To monitor this plan of correction, the facility will continue to work with our corporate recruiter, to actively seek and recruit both certified aides and applicants willing to be certified as CNAs by going through our CNA class which is conducted in collaboration with ACE Healthcare Training Institute. Also, there is a weekly staff recruitment call session with our corporate recruiter, the staffing coordinator, HR manager, Director of Nursing and the Administrator to discuss staffing and the recruitmment efforts. The report from these meetings will be reviewed with the QAPI committee, monthly and at each quartely meeting. The Administrator will monitor this plan of correction for weekly for two months. The QAPI committee reviewed this plan of correction on 4/19/2024 and has approved it as a means of ensuring compliance.	

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S 560	Continued From page 2 the day shift, required at least 17 CNAs. On 03/24/24 had 15 CNAs for 136 residents on the day shift, required at least 17 CNAs. On 03/25/24 had 12 CNAs for 136 residents on the day shift, required at least 17 CNAs. On 03/26/24 had 15 CNAs for 136 residents on the day shift, required at least 17 CNAs. On 03/27/24 had 15 CNAs for 136 residents on the day shift, required at least 17 CNAs. On 03/28/24 had 17 CNAs for 144 residents on the day shift, required at least 18 CNAs. On 03/29/24 had 11.5 CNAs for 144 residents on the day shift, required at least 18 CNAs. On 03/30/24 had 7 CNAs for 144 residents on the day shift, required at least 18 CNAs.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315137 Y1	A. Building B. Wing Y2	4/29/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BARN HILL CARE AND REHAB CENTER	249 HIGH STREET NEWTON, NJ 07860

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 F0656	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/22/2024	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	
4/9/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061903 Y1	A. Building B. Wing Y2	4/29/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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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	04/22/2024	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	
4/9/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO