

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061905	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/21/2021
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & HEALTH CAI		STREET ADDRESS, CITY, STATE, ZIP CODE 129 MORRIS TURNPIKE 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) COMPLETE DATE
S 560	<p>8:39-5.1(a) Mandatory Access to Care</p> <p>(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint # NJ 146772</p> <p>Based on observation, interviews, and review of pertinent facility documentation on 10/21/2021, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for 14 of 14 day reviewed. This deficient practice was evidenced by the following:</p> <p>Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "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 2/01/21:</p> <p>One Certified Nurse Aide (CNA) to every eight residents for the day shift.</p> <p>During an interview with the surveyor on 10/21/21 at 12:08 p.m., a CNA stated she was assigned to 14 residents that day and usually assigned 12-14 residents on the day shift. The CNA stated she still had 2 residents to give am care to in addition to toileting, and monitoring residents who have dementia.</p>	S 560	<p>SPECIFIC CORRECTIVE ACTION:</p> <p>The facility is actively recruiting license staff and certified nursing assistant by placing an ad and working directly with recruitment agency</p> <p>The facility has instituted a sign-on bonus, and employee referral program.</p> <p>The facility has instituted incentive programs for current staff to assist with covering staffing requirements.</p> <p>IDENTIFICATION:</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>SYSTEMIC CHANGES:</p> <p>The DON will work with the Staffing Coordinator in reviewing the Nursing/CNA Monthly Schedule to ensure appropriate staffing is in place.</p> <p>The facility will continue to work closely with Staffing Agencies in utilizing agency staff ensuring monthly schedule for their staff.</p>	11/4/21

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

Electronically Signed

TITLE

(X6) DATE

11/04/21

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061905	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/21/2021
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & HEALTH CAI		STREET ADDRESS, CITY, STATE, ZIP CODE 129 MORRIS TURNPIKE 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) COMPLETE DATE
S 560	<p>Continued From page 1</p> <p>The CNAs were responsible for providing direct care to the residents.</p> <p>The surveyor requested staffing for the weeks of 7/4/2021 and 7/11/2021.</p> <p>Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the following:</p> <p>The facility was deficient in CNA staffing on 14 of 14 day shifts as follows:</p> <p>07/04/21 had 6 CNAs for 73 residents on the day shift, required 10 CNAs.</p> <p>07/05/21 had 7 CNAs for 73 residents on the day shift, required 10 CNAs.</p> <p>07/06/21 had 8 CNAs for 73 residents on the day shift, required 10 CNAs.</p> <p>07/07/21 had 9 CNAs for 73 residents on the day shift, required 10 CNAs.</p> <p>07/08/21 had 6 CNAs for 73 residents on the day shift, required 10 CNAs.</p> <p>07/09/21 had 7 CNAs for 73 residents on the day shift, required 10 CNAs.</p> <p>07/10/21 had 7 CNAs for 73 residents on the day shift, required 10 CNAs.</p> <p>07/11/21 had 6 CNAs for 73 residents on the day shift, required 10 CNAs.</p> <p>07/12/21 had 7 CNAs for 75 residents on the day shift, required 10 CNAs.</p> <p>07/13/21 had 9 CNAs for 75 residents on the day shift, required 10 CNAs.</p> <p>07/14/21 had 8 CNAs for 75 residents on the day shift, required 10 CNAs.</p> <p>07/15/21 had 8 CNAs for 75 residents on the day shift, required 10 CNAs.</p>	S 560	<p>MONITORING:</p> <p>The Human Resource Manager or designee will conduct a monthly audit of calls outs and recruitment efforts and bring the findings to the QAPI Committee for further recommendations and/or action plans as needed.</p>	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061905	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/21/2021
NAME OF PROVIDER OR SUPPLIER HOMESTEAD REHABILITATION & HEALTH CAI		STREET ADDRESS, CITY, STATE, ZIP CODE 129 MORRIS TURNPIKE 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) COMPLETE DATE
S 560	<p>Continued From page 2</p> <p>During an interview with the surveyor on 10/21/2021 at 12:21 p.m., the staffing coordinator stated that the facility was aware of the staffing ratios and they were trying to meet the requirements.</p> <p>During an interview on 10/21/2021 at 9:12 a.m., the Director of Nursing (DON) stated that the facility was aware of the staffing ratios.</p>	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 061905	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT Y2 11/15/2021 Y3
NAME OF FACILITY HOMESTEAD REHABILITATION & HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 129 MORRIS TURNPIKE NEWTON, NJ 07860

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
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 11/04/2021	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed LSC _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed LSC _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed LSC _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed LSC _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed LSC _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed LSC _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed LSC _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed LSC _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed 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 10/21/2021		<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			