STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315064	A. BUILDING _____ B. WING _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBROOK CARE & REHABILITATION CENTER	**1610 RARITAN ROAD SCOTCH PLAINS, NJ 07076**

(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 A Complaint Survey was conducted on behalf of the New Jersey Department of Health. Complaint #: NJ00150937, NJ00153274, NJ00153719, NJ00153982, NJ00155208, NJ00158457, NJ00159724, NJ00169699, NJ00169728, NJ00171511, NJ00172200, NJ00172238, and NJ00172365. Survey Dates: 05/13/24-05/15/24 Survey Census: 92 Sample Size: 16 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 | 07/04/2024

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
	062002	A. BUILDING: _____ B. WING _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBROOK CARE & REHABILITATION CENTER	1610 RARITAN ROAD SCOTCH PLAINS, NJ 07076

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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 #: NJ00150937, NJ00153274, NJ00153719, NJ00153982, NJ00155208, NJ00158457, NJ00159724, NJ00169699, NJ00169728, NJ00171511, NJ00172200, NJ00172238, and NJ00172365. 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 15 shifts as followss: 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 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 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift.	S 560	I. Corrective action Staffing was reviewed by the Director of Nursing and Administrator; no residents were affected negatively by the deficient practice. The facility cannot retroactively respond to the staffing ration prior to the complaint survey. II. ID others with potential to be affect All residents have potential to be affected by the deficient practice. III. Systemic changes The Director of Human Resources (HR) initiated an expedited on-boarding process for all new hires. Interviews will be conducted on the spot with job offer (contingent of background check). Job openings are posted on all recruitment cites. Meeting with DON/designee will review staffing with staffing coordinator and collectively work to fill out any open shifts and callouts. Bonuses are offered to staff as needed. HR manager will contact and work with nursing and CNA schools to recruit staff. Director of Nursing will contact nursing schools to partner to be a training facility for nursing school and CNA and offer	7/31/24

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

Electronically Signed | 07/04/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062002	A. BUILDING: _____ B. WING _____	C 05/15/2024

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S 560	Continued From page 1 One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA 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. As per the "Nurse Staffing Report" completed by the facility for the 2 weeks of staffing from 4/28/24 to 5/11/24, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -04/28/24 had 7 CNAs for 96 residents on the day shift, required at least 12 CNAs. -04/29/24 had 6 CNAs for 96 residents on the day shift, required at least 12 CNAs. -04/29/24 had 6 total staff for 96 residents on the overnight shift, required at least 7 total staff. -04/30/24 had 8 CNAs for 94 residents on the day shift, required at least 12 CNAs. -05/01/24 had 8 CNAs for 94 residents on the day shift, required at least 12 CNAs. -05/02/24 had 10 CNAs for 94 residents on the day shift, required at least 12 CNAs. -05/03/24 had 9 CNAs for 92 residents on the day shift, required at least 11 CNAs. -05/04/24 had 7 CNAs for 92 residents on the day shift, required at least 11 CNAs. -05/05/24 had 7 CNAs for 92 residents on the day shift, required at least 11 CNAs. -05/06/24 had 6 CNAs for 92 residents on the day shift, required at least 11 CNAs.	S 560	positions once students graduate. The DON/Designee will monitor staffing ratios daily and document a review of staffing weekly for 2 months. IV. Monitoring Audits will be presented to the Administrator weekly. Audits will be discussed at the monthly QAPI meetings to determine if continued auditing is needed . Once compliance is achieved for 2 consecutive months, the plan will be amended as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062002	A. BUILDING: _____ B. WING _____	C 05/15/2024

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S 560	Continued From page 2 -05/07/24 had 9 CNAs for 91 residents on the day shift, required at least 11 CNAs. -05/08/24 had 8 CNAs for 91 residents on the day shift, required at least 11 CNAs. -05/09/24 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. -05/10/24 had 7 CNAs for 90 residents on the day shift, required at least 11 CNAs. -05/11/24 had 7 CNAs for 90 residents on the day shift, required at least 11 CNAs.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
062002 Y1	A. Building B. Wing Y2	7/11/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBROOK CARE & REHABILITATION CENTER	1610 RARITAN ROAD SCOTCH PLAINS, NJ 07076

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	07/11/2024	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	
5/15/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO