

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

PRINTED: 09/27/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/27/2024
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NAME OF PROVIDER OR SUPPLIER TALLWOODS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 18 BUTLER BOULEVARD BAYVILLE, NJ 08721
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>Complaint #: NJ167953</p> <p>Census: 141</p> <p>Sample Size: 4</p> <p>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.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 09/03/2024
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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.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 656005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/27/2024
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NAME OF PROVIDER OR SUPPLIER TALLWOODS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 18 BUTLER BOULEVARD BAYVILLE, NJ 08721
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S 000	<p>Initial Comments</p> <p>Complaint #: NJ167953</p> <p>Census: 141</p> <p>Sample Size: 4</p> <p>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.</p>	S 000		
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 #: NJ167953</p> <p>Based on interviews and review of facility documents on 08/27/2024, it was determined that the facility failed to ensure staffing ratios were met for 5 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents.</p> <p>Findings include:</p>	S 560	<p>1. No residents were identified on the 2567 as have been affected by the deficient practice</p> <p>2. This deficient practice has the potential to affect all residents</p> <p>3. Staffing coordinator was educated by the administrator regarding the mandatory staffing ratios and instructed to update the contact information of all current licensed personnel so staff can be called in to meet staffing needs in case of call outs.</p>	9/3/24

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

TITLE

(X6) DATE

Electronically Signed

09/03/24

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 656005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/27/2024
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NAME OF PROVIDER OR SUPPLIER TALLWOODS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 18 BUTLER BOULEVARD BAYVILLE, NJ 08721
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S 560	<p>Continued From page 1</p> <p>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:</p> <p>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.</p> <p>For the 2 weeks of staffing prior to complaint survey from 08/11/2024 to 08/24/2024, the facility was deficient in CNA staffing for residents on 5 of 14-day shifts as follows:</p> <p>On 08/11/24 had 16 CNAs for 146 residents on the day shift, required at least 18 CNAs. On 08/15/24 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs. On 08/17/24 had 16 CNAs for 143 residents on the day shift, required at least 18 CNAs.</p> <p>On 08/18/24 had 16 CNAs for 146 residents on the day shift, required at least 18 CNAs. On 08/24/24 had 16 CNAs for 141 residents on the day shift, required at least 18 CNAs.</p>	S 560	4. staffing ratios will be monitored daily by administrator or designee for 30 days to ensure compliance. Administrator will audit staffing reports monthly for 3 months. Results will be reported quarterly to the QAPI meeting for two quarters.	
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STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 656005	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 9/11/2024
NAME OF FACILITY TALLWOODS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 18 BUTLER BOULEVARD BAYVILLE, NJ 08721	

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	09/03/2024	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 <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 8/27/2024		<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 		