STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315010	A. BUILDING _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORA HILLS HEALTH & REHABILITATION CENTER	**225 W JERSEY STREET ELIZABETH, NJ 07202**

(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 C#: NJ163928 and NJ00166517 Census: 181 Sample Size: 4 THE FACILITY IS IN 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 | 05/03/2024

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
	32003	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORA HILLS HEALTH & REHABILITATION CENTEF	225 W JERSEY STREET ELIZABETH, NJ 07202

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S 000	Initial Comments C#: NJ163928 and NJ00166517 The facility was 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 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00166517 and NJ00163928 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 16 of 28 day shifts. The deficient practice was evidenced by the following: 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	S 560	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A thorough review of resident care records on 3/12/2023, 3/19/2023, and the period of 3/17/2024 through 3/30/2024 was conducted. No complaints or grievances related to resident care on the day shift were discovered. This indicates that no residents were adversely affected by the deficient practice. 2. How will you identify other residents	5/17/24

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

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	32003	A. BUILDING: _____ B. WING _____	C 04/02/2024

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ELMORA HILLS HEALTH & REHABILITATION CENTEF	225 W JERSEY STREET ELIZABETH, NJ 07202

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S 560	Continued From page 1 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 ten 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 fourteen 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 surveyor requested staffing for the weeks of 03/12/23 to 03/18/23, 03/19/2023 to 03/25/23, 03/17/2024 to 03/23/2024, and 03/24/2024 to 03/30/2024. For the 2 weeks of Complaint staffing from 03/12/2023 to 03/25/2023, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -03/12/23 had 19 CNAs for 173 residents on the day shift, required at least 22 CNAs. -03/19/23 had 19 CNAs for 173 residents on the day shift, required at least 22 CNAs. For the 2 weeks of Complaint staffing from 03/17/2024 to 03/30/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -03/17/24 had 22 CNAs for 189 residents on the day shift, required at least 24 CNAs.	S 560	having the potential to be affected by the same deficient practice and what corrective action will be taken? The deficient practice has the potential to affect all residents residing in the facility. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? To prevent recurrence of the staffing shortage, the facility has implemented the following measures: 1. Education & Accountability: The Staffing Coordinator has received thorough re-education by the DON on The State of New Jersey Department of Health requirement on the minimum ratio of one Certified Nurse Aide (CNA) to every eight residents for day shift. 2. Proactive Staffing: The Staffing Coordinator will conduct daily assessments of staffing needs to proactively identify and address potential shortages. 3. Contingency Plan: In event of a CNA shortage where the ratio of one CNA to every eight residents on day shift will not being met, a multi-pronged plan is in place: • The nurse manager/supervisors will recruit CNA from previous or upcoming shift, • Staffing coordinator and nursing management have the authority to utilize agency companies for staffing support, and • The CNA unit clerk may be reassigned	

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	32003	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 2 -03/18/24 had 21 CNAs for 189 residents on the day shift, required at least 24 CNAs. -03/19/24 had 22 CNAs for 189 residents on the day shift, required at least 24 CNAs. -03/20/24 had 23 CNAs for 189 residents on the day shift, required at least 24 CNAs. -03/21/24 had 22 CNAs for 193 residents on the day shift, required at least 24 CNAs. -03/22/24 had 20 CNAs for 193 residents on the day shift, required at least 24 CNAs. -03/23/24 had 21 CNAs for 193 residents on the day shift, required at least 24 CNAs. -03/24/24 had 23 CNAs for 191 residents on the day shift, required at least 24 CNAs. -03/25/24 had 22 CNAs for 191 residents on the day shift, required at least 24 CNAs. -03/26/24 had 21 CNAs for 191 residents on the day shift, required at least 24 CNAs. -03/27/24 had 20 CNAs for 188 residents on the day shift, required at least 23 CNAs. -03/28/24 had 22 CNAs for 188 residents on the day shift, required at least 23 CNAs. -03/29/24 had 20 CNAs for 185 residents on the day shift, required at least 23 CNAs. -03/30/24 had 22 CNAs for 185 residents on the day shift, required at least 23 CNAs.	S 560	to assist with providing direct resident care. 4. Recruitment: The facility is actively recruiting new employees. Strategies include offering referral and sign-on bonuses, utilizing online advertisements, and recruiting candidates from local CNA training programs. 4. How the corrective action be monitored to ensure the deficient practice will not recure, i.e. What quality assurance program will be put into place? The facility will implement the following monitoring and quality assurance program: • Accountability: The LNHA, DON, or their designee will be responsible for conducting audits. • Weekly Audits: Weekly CNA staffing schedule audits will be conducted for 4 weeks to establish immediate compliance. • Transition to Monthly Audits: Audits will then transition to monthly for 3 months to ensure sustained compliance. • Reporting: The DON or designee will report audit findings to the LHNA for timely corrective action if needed. • QAPI Integration: Audit findings and any corrective actions taken will be reviewed during quarterly Quality Assurance and Performance Improvement (QAPI) meetings to ensure continuous monitoring and prevent recurrence.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
32003 Y1	A. Building B. Wing Y2	5/17/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORA HILLS HEALTH & REHABILITATION CENTER	225 W JERSEY STREET ELIZABETH, NJ 07202

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 Reg. # 8:39-5.1(a) LSC	Correction Completed 05/17/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
4/2/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO