STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315485	A. BUILDING _____ B. WING _____	C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT WALL	**2621 HIGHWAY 138 WALL, NJ 07719**

(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 NJ00147567, NJ00148594 SURVEY DATE: 9/30/21 CENSUS: 105 SAMPLE: 8 THE FACILITY IS NOT IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART483,SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609		10/25/21

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

Electronically Signed | 10/18/2021

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F 609	Continued From page 1 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: NJ00147567 Based on interviews, review of medical records and other pertinent facility documentation, it was determined that the facility failed to notify administration of an allegation of mistreatment and report that allegation to the New Jersey Department of Health (NJDOH) for 1 of 3 residents reviewed for abuse (Resident [redacted]). This deficient practice was evidenced by the following: On 9/30/21, the surveyor reviewed the closed electronic Medical Record (MR) for Resident [redacted] who was previously discharged from the facility. A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that at the time of admission, the resident had a brief interview for mental status (BIMS) score of [redacted] indicating he/she had an [redacted] with [redacted]. A review of the Admission Record face sheet (an admission summary) indicated that the resident had diagnoses which included a [redacted] A review of the resident's electronic progress	F 609	1.Resident [redacted] no longer resides at the facility. However, upon learning about the alleged violation, the facility DON reached out to the resident and interviewed Resident related to the allegation and to inform the resident that a thorough investigation immediately. The conclusion of the investigation was that the allegation of abuse was not substantiated. commenced . The allegation was called into NJDOHSS on 9/30/21 at 3:36 PM 2. Any residents have the potential to be affected by the deficient practice. 3.the facility reinforced the review of 24 hour documentation report during clinical meetings. The facility reinforced the Ambassador Program focused on eliciting feedback from alert and oriented residents regarding their overall care experience in the facility. in order to assure cognately impaired residents benefit from this protocol, Ambassadors will report on their observations of these residents , as well as contacting their responsible parties with any issues. The DON/ADON provided reeducation and in service to all staff on October 3thd 2021.on abuse identification and prevention reporting. any identified allegations of abuse, neglect or mistreatment will be reported to the	

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F 609	Continued From page 2 notes revealed a nursing note dated [redacted] at 4:02 PM "...patient also complained of aide at night that does not treat [him/her] well, informed [him/her] to let nurse know [he/she] would not like to have that aide when [he/she] sees [him/her] again, patient verbalized understanding with no further questions..." The note was signed by a Licensed Practical Nurse (LPN). A review of the resident's individualized comprehensive care plan (ICCP) dated as revised and canceled on [redacted] had not indicated any preference regarding an aide assignment. On 9/30/21 at 2:00 PM, the surveyor interviewed the Director of Rehab (DOR) who stated that she remembered and was familiar with Resident [redacted]. The DOR was able to review past physical therapy notes regarding Resident [redacted] and stated that the resident had physical therapy services from [redacted] and was slightly confused upon admission. The DOR added that the resident's cognition had improved during the stay and the resident became more alert and oriented and was able to make his/her needs known. On 9/30/21 at 3:36 PM, the surveyor interviewed the Director of Nursing (DON) who stated that there were no incident reports, filed grievances, or reportable events for Resident [redacted]. On 9/30/21 at 4:34 PM, the surveyor conducted a phone interview with the LPN who wrote the progress note dated [redacted]. The LPN stated that she had worked at the facility from [redacted] and no longer worked at the facility. The LPN stated that she was familiar with Resident [redacted] and confirmed she had written the	F 609	NJDOHSS. The administrator or DON or designee is responsible in reporting the incident to the NJDOHSS 4.THe DON and ADON performed chart audits residents, which stated on October 3thd, 2021.No deficient practice identified. The Social Services Director interviewed alert and oriented residents' regarding their overall experience on October 8, 2021. Social Services Director will continue to perform random audits. The DON /ADON or designee will review incident reports 2x weekly and then weekly for 4 weeks The Social Worker will be auditing identified grievance concerns 2x for 2 weeks and then once a week for 2 weeks The results of the incident reports and grievance audits will be forwarded to the facility QAPI Committee for further review and recommendations	

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progress note dated [redacted] at 4:02 PM. The LPN explained that the resident had told her that he/she felt that an unidentified Certified Nursing Aide (CNA) had not treated him/her well and the resident could not give a name, description or a date of when the incident allegedly occurred. The LPN stated that she wrote that it was the "night" CNA because the resident thought it was dark out when he/she had the alleged encounter with the CNA. The LPN continued that since the resident was unable to identify the CNA staff member, she had told the resident when he/she saw that same CNA again in the future to then let a nurse know on that shift. The LPN stated that the resident was also not able to give a description of what had occurred so at that time she did not feel that anything further could be done. The LPN emphasized that Resident [redacted] had made a general statement with no specific information, and there was no need for her to report the statement to the administration. The LPN added that she thought the resident had stated that he/she told other staff members, but the resident could not speak to any names. The LPN also added that she thought she had reported it to the oncoming shift nurse during shift-to-shift report, but she was unsure of who she may have informed or if there was any further documentation.

The surveyor continued to interview the LPN who stated that she had received in-service training regarding abuse during her orientation and was told to report any complaint so that it could be investigated. The LPN then stated that she did not feel at that time that she needed to report this statement to anyone because she felt that it was so "vague" and the resident had no specific information. The LPN stated that she did not feel concerned for the resident because he/she could

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F 609	Continued From page 4	F 609		

speak for themselves.

On 9/30/21 at 5:18 PM, the surveyor, in the presence of another surveyor, interviewed the DON who stated that she had been the DON at the facility since [redacted] and was not familiar with Resident [redacted]. The DON stated that she had not received any concerns or information regarding Resident [redacted] and no interaction with any of the resident's representatives.

At that time, the surveyor asked the DON for any information regarding the LPN. The DON stated that the LPN had been employed for a short period of time. The DON stated that she had not had any issues with the LPN.

On 9/30/21 at 5:40 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that she remembered and was familiar with Resident [redacted]. The RN/UM stated that the resident had one (1) family representative designated as a contact that she would update regarding any issues during the resident's stay until just before discharge another family representative was added as a second contact. The RN/UM stated that the resident was initially forgetful on admission and then improved and was able to make their needs known. The RN/UM added that she had cared for the resident and had a good rapport with him/her. The RN/UM explained that the resident was particular on how to position his/her [redacted] and [redacted] that occurred at home. The RN/UM also stated that the resident had [redacted] and was administered [redacted] medications to help alleviate the [redacted]. The RN/UM stated that the resident had not voiced any complaints or concerns regarding staff members to her. The RN/UM also stated that the

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family member who was the primary contact had not voiced any complaints or concerns regarding staff members during or after the resident's stay.

At that time, the surveyor asked the RN/UM for any information regarding the LPN. The RN/UM stated that the LPN had worked on the unit for a short time. The RN/UM stated that she thought the LPN mostly worked the 7 AM to 3 PM day shift and could have worked the 3 PM to 11 PM evening shift also. The RN/UM stated that the LPN had not reported any concerns or complaints regarding Resident [redacted] to her during the LPN's time of employment.

On 9/30/21 at 5:53 PM, the surveyor interviewed the DON and the RN/UM together. The RN/UM stated that staff were to report to her any resident concerns and immediately report any fall or skin issue that occurred to a resident. The RN/UM then stated that any nurse who received a complaint about a CNA or any staff member was to report it to her immediately and then she would immediately notify the DON in accordance with their policy. The DON then stated that she and the Social Worker (SW) would go to the resident who had a concern to obtain further information and investigate the allegation. The DON also stated that she would report any allegation to the NJDOH. The DON also stated that during the investigation the CNA or other staff member would be suspended until the investigation was completed and a determination was made.

On 9/30/21 at 6:16 PM, the surveyor, in the presence of another surveyor, interviewed the Director of SW (DSW) who stated that she was familiar with Resident [redacted]. The DSW added that there was a care conference completed on [redacted] during a time requested by the family

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representative but the family representative was unable to attend by telephone. The DSW added that the resident was in attendance and was alert and oriented to person, place and time and could make his/her needs known so the conference meeting continued as per the request of the resident. The DSW stated that the resident was satisfied at that time and was looking forward to being discharged. The DSW also stated that she was in contact with both family representatives around the discharge date and was not told of any issues, concerns, or complaints regarding any staff member. The DSW referred to progress notes that she had documented on [redacted] at 1:30 PM. [redacted] at 7:35 PM, [redacted] at 5:00 PM and [redacted] at 3:28 PM regarding documentation of conversations with the resident and family members. The DSW stated that any concerns or complaints regarding a staff member would have been documented in her notes and followed up by herself with the DON by obtaining a statement from the resident involved and completing an investigation.

On 9/30/21 at 6:41 PM, the surveyor, in the presence of another surveyor, interviewed the DON who stated that she was unaware of any specific concerns regarding the LPN. The DON added that all employees are in-serviced on abuse prevention and notification.

A review of the LPN employment file revealed that the LPN had been in-serviced on Abuse and Neglect on 6/17/21.

A review of the facility policy dated as revised April 2021 on "Abuse, Neglect, Exploitation and Misappropriation Prevention Program provided by the DON included a facility wide commitment and resource allocation to support identifying and

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F 609	Continued From page 7 investigating all possible incidents of abuse, neglect, mistreatment or misappropriation of resident property. Further review revealed the facility will investigate and report any allegations within timeframe's required by federal requirements. NJAC 8:39-9.4(e)(3)(i)	F 609		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: NJ00148594 Based on observation, interview and review of the medical record and other facility documentation, it was determined that the facility failed to: a.) appropriately the assess and document a resident's skin condition, b.) accurately document a resident's [redacted] status to ensure the resident received necessary treatment and services to promote the healing of a [redacted] and c.) follow a physician's order for a [redacted] treatment in accordance with professional standards of nursing practice. This deficient practice was identified for 1 of 2 residents reviewed for [redacted] (Resident [redacted]) Reference: New Jersey Statues, Annotated Title 45, Chapter. Nursing Board The Nurse Practice Act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical	F 658	1. Resident [redacted] no longer resides at the facility. The nurse was in-serviced on 10/3/21 regarding [redacted] care, skin assessments and [redacted] scale, reporting and follow-up with physician or [redacted] care physician. 2. Any resident has the potential to be affected by the deficient practice. 3. The DON and the Clinical Team performed an audit of all residents admitted in the facility with compromised skin integrity and ensure care place were updated and in place. The DON/ADON provided re-education to the nursing staff regarding skin assessment completion and weekly skin checks for new admissions as well as existing residents. Findings must be documented in PCC. 4. The DON/ADON or designee will monitor will monitor all residents with skin	10/22/21

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F 658	Continued From page 8 and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well being, and executing a medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities with in the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." The evidence was as follows: On 9/30/21 at 11:00 AM, the surveyor reviewed the electronic medical record of Resident [redacted] who was discharged to the hospital on [redacted] and had not yet been re-admitted to the facility. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to, [redacted]. A review of the Universal Transfer Form (UTF), a communication tool between healthcare facilities, dated [redacted], indicated that Resident [redacted] was transferred to the facility from the hospital. The UTF, under the section Skin Conditions, indicated	F 658	integrity issues this will be done three times a week for two weeks, then two times a week for two weeks, then once a week for eight weeks. Total of 12 weeks of monitoring. one full quarter of the calendar, The DON /ADON or designee will ensure completed audits are followed up, by reviewing the findings , the report a the summary to administrator and as well as to QAPI quarterly to ensure compliance . The QAPI team will determine if further action is required.	

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F 658	Continued From page 9 that Resident [redacted] had a [redacted] on the [redacted]. A review of the Resident Evaluation with [redacted] screen, completed on admission on [redacted], indicated that Resident [redacted] did not have any current skin breakdown or skin conditions. (This did not accurately correspond to the UTF dated [redacted] which indicated that the resident had a [redacted]). A review of the Progress Notes (PN) indicated that on [redacted] at 18:06, Resident [redacted] skin assessment was clear. A review of the [redacted] Scale for Predicting [redacted] Risk indicated that Resident [redacted] risk for a [redacted] was assessed to be at high risk for developing a [redacted] on [redacted] and [redacted]. A further review of Resident [redacted] PN included the following: On 8/20/21 at 11:13 AM: "during AM care staff noted [redacted], assessment [redacted] All parties notified, treatment put in place, air mattress ordered." (There was no documented evidence in the PN from [redacted] to [redacted] that the resident had any skin conditions, discolorations, or breakdown.) A review of the resident's individualized care plan indicated that Resident [redacted] had actual skin [redacted] related to [redacted] which was initiated on [redacted].	F 658		

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On 9/30/21 at approximately 1:30 PM, the surveyor asked the Assistant Director of Nursing (ADON) if Resident [redacted] had a [redacted] on admission which was indicated on the UTF from the hospital, but was not reflected in the facility's admission documents. At approximately 2:00 PM, the ADON stated that he spoke with the admitting nurse and that she told him that Resident [redacted] had [redacted] and that the staff were using a barrier cream on the area. The ADON could not give a reason why the [redacted] was not documented.

A review of the [redacted] Treatment Administration Record (TAR) included a physician order dated [redacted], for weekly skin observations every Friday evening shift with the following codes to be used; 0-NO skin breakdown, 1-Previously identified wound, 2-Newly identified wound. The staff documented on [redacted] and [redacted] a checkmark which according to the Chart Codes/Follow Up Codes indicated the order was administered. There was no documented coding on those dates to indicate if Resident [redacted] had no skin [redacted] a previously identified [redacted] or a newly identified [redacted], in accordance with the physician's order. Further review of the TAR indicated a physician order dated [redacted] for a [redacted] Dressings). The order specified to apply the [redacted] topically every day shift for [redacted] cleanse with [redacted], pat dry, apply [redacted] cover with cdd (clean, dry, dressing) and prn (as needed). The order had a discontinue date of [redacted]. There was no documentation that the treatment was carried out on [redacted] in accordance with the physician's order.

A review of the PN for [redacted] did not reveal

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documented evidence that the [redacted] treatment had been performed on [redacted].

On 9/30/21 at approximately 2:25 PM, the surveyor asked the Director of Nursing (DON) to provide any documentation of Resident [redacted]s comprehensive skin assessment. The DON stated that skin assessments were done on admission.

At approximately 3:15 PM, the surveyor asked the DON to provide the surveyor with any documentation of Resident [redacted].

At approximately 3:40 PM, the DON provided the surveyor Resident [redacted] care report dated [redacted], which included the following: wound assessment-Initial exam of a [redacted]. (This was the first date the [redacted] was [redacted], which is 11 days after [redacted]). [redacted]] injury [redacted]

On 9/30/21 at 5:48 PM, the surveyor asked the DON if any documented comprehensive skin assessment was done during Resident [redacted] stay. The surveyor also asked if any documented [redacted] were done at the time of the [redacted] or any time prior to the [redacted] care physician's assessment was done on [redacted]. The DON stated that there was no facility form used for the skin assessment and that it was included in another document. She then stated that there was no documented [redacted] done at the time of the [redacted] or any time prior to the [redacted] care

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F 658	Continued From page 12 physician's assessment done on [redacted]. She further stated that the nurse that did the initial assessment was not comfortable doing the measurements. The DON then stated that since then, the facility had the wound care physician come to the facility and educate the staff about documentation of [redacted] The surveyor asked the DON about the skin observations on Resident [redacted] TAR. The DON stated that the staff should have documented the corresponding numbers to indicate what the status of the resident's skin was and that it should not have been a check mark to indicate that the observation was performed. The surveyor then asked the DON about the different assessments of Resident [redacted] skin on the UTF from the hospital and the admission document at the facility. The DON stated that she could not speak to what was on the UTF and that she could only go by the assessment that her staff performed. The facility could not provide any documentation of a facility-approved comprehensive skin assessment. The facility could not provide any documentation of the [redacted] assessment with [redacted] which would be used to assess whether the treatment was promoting the healing of the [redacted] A review of the facility provided policy titled, "[redacted] Injury Risk Assessment", with a revised date of March 2020, indicated the following: Steps in the procedure 1. Gather assessment tools and documentation and conduct the assessment in the manner most appropriate to the resident's condition and willingness to participate. 3. Conduct a structured [redacted] injury risk assessment using a facility-approved tool. 4. Conduct a comprehensive skin assessment	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315485	A. BUILDING _____ B. WING _____	C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 13 with every risk assessment. b. Once inspection of skin is completed document the findings on a facility-approved skin assessment tool. c. If a new skin alteration is noted, initiate a ([redacted]) form related to the type of alteration in skin. Documentation The following information should be recorded in the resident's medical record utilizing facility forms: 1. The type of assessment(s) conducted. 2. The date and time and type of skin care provided, if appropriate ... 4. Any change in the resident's condition, if identified. 5. The condition of the resident's skin (i.e., the size and location of any red or tender areas), if identified ... 11. Initiation of a ([redacted]) form related to the type of alteration in skin if new skin alteration noted. Reporting 2. Report other information in accordance with facility policy and professional standards of practice. N.J.A.C. 8:39-27.1 (a)	F 658		

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	556213	A. BUILDING: _____ B. WING _____	C 09/30/2021

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S 000	Initial Comments NJ00147567, NJ00148594 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: NJ00147567, NJ00148594 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. The facility was deficient in CNA staffing for 22 of 35 day shifts as follows: Findings include: Reference: New Jersey Department of Health	S 560	1. The leadership team has met on on ongoing basis and continue to identify staffing challenges and areas of improvement for licensed and certified staffing needs. 2. Any residents have the potential to be affected by the deficient practice. 3. The facility has implemented significant above market rate for nurses and certified nurses aides. Including sign on bonus when applicable The facility continues to conduct ongoing job fairs with immediate	10/21/21

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

Electronically Signed | 10/18/21

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 (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. 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 weeks of 8/1/21 to 9/4/21, the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below: -8/1/21 had 12 CNAs for 127 residents on the day shift (required no more that 8 residents for each CNA). -8/2/21 had 12 CNAs for 124 residents on the day shift. -8/3/21 had 12 CNAs for 124 residents on the day shift. -8/4/21 had 12 CNAs for 124 residents on the day shift.	S 560	interviews and contingency offers. The facility implemented expediated but robust onboarding process for new hires. The facility will use agency staff as needed to meet staffing needs. The facility will utilize licensed nurses in the leadership team to complement call outs or no show employees as needed. Non licensed staff will assist in rounding and assisting residents when they can. The facility will use agency staff to cover call outs and no show staff 4. Director of Nursing/ ADON will meet with the Staffing Coordinator on a daily basis The DON or her designee reviews any call outs on a daily basis and proactively make and effort to replace staff members. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. the DON and ADON will monitor call outs and no shows and submit findings to teh Administrator and QAPI Committee for further review and recommendation	

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S 560	Continued From page 2 -8/5/21 had 14 CNAs for 124 residents on the day shift. -8/6/21 had 12 CNAs for 126 residents on the day shift. -8/7/21 had 12 CNAs for 124 residents on the day shift. -8/8/21 had 10 CNAs for 124 residents on the day shift. -8/9/21 had 15 CNAs for 124 residents on the day shift. -8/10/21 had 15 CNAs for 124 residents on the day shift. -8/14/21 had 10 CNAs for 124 residents on the day shift. -8/15/21 had 13 CNAs for 124 residents on the day shift. -8/17/21 had 15 CNAs for 121 residents on the day shift. -8/22/21 had 11 CNAs for 105 residents on the day shift. -8/23/21 had 12 CNAs for 105 residents on the day shift. -8/24/21 had 12 CNAs for 105 residents on the day shift. -8/25/21 had 12 CNAs for 107 residents on the day shift. -8/26/21 had 13 CNAs for 107 residents on the day shift. -8/28/21 had 10 CNAs for 104 residents on the day shift. -8/29/21 had 11 CNAs for 101 residents on the day shift. -8/30/21 had 12 CNAs for 101 residents on the day shift. -9/4/21 had 11 CNAs for 109 residents on the day shift. On 9/30/21 at 6:03 PM, the surveyor interviewed the Director of Nursing who confirmed that the facility was aware of the required minimum direct care	S 560		

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S 560	Continued From page 3 staff to resident ratios. She stated that the facility was trying to meet the ratios. NJAC 8:39-5.1(a)	S 560		