STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315260	A. BUILDING ______ B. WING ______	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	**600 PEMBERTON BROWN MILLS RD PEMBERTON, NJ 08068**

(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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Survey Date: 10/17/22 Census: 175 Sample: 35 + 1 closed record A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 690		12/5/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 11/08/2022

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
	315260	A. BUILDING ______ B. WING ______	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	600 PEMBERTON BROWN MILLS RD PEMBERTON, NJ 08068

(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 690	Continued From page 1 catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to maintain an NJ Exec. Order 26:4.b.1 off the floor to prevent the spread of infection and according to the facility protocol. This was identified for 1 of 2 residents (Resident #18) reviewed for NJ Exec. Order 26:4.b.1. This deficient practice was evidenced by the following: On 10/04/2022 at 10:34 AM, the surveyor observed Resident #18 in a wheelchair in the hallway near the nurse's station. The surveyor observed a NJ Exec. Order 26:4.b.1 was attached to his/her wheelchair and the [redacted] had direct contact with the floor.	F 690	I. Corrective action(s)accomplished for resident(s)affected: • The NJ Exec. Order 26:4.b.1 for Resident #18 was anchored to the bed, in a NJ Exec. Order 26:4.b.1 not touching the floor. • Resident #18 had no negative outcomes related to the NJ Exec. Order 26:4.b.1 NJ Exec. Order 26:4.b.1 findings. • The identified nursing staff caring for the resident was re-educated on the NJ Exec. Order 26:4.b.1 Protocol. II. Residents identified having the potential to be affected and corrective action taken: • All residents who have an [redacted]	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315260	A. BUILDING ______ B. WING ______	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	600 PEMBERTON BROWN MILLS RD PEMBERTON, NJ 08068

(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 690	Continued From page 2 On 10/06/2022 at 12:00 PM the surveyor observed Resident #18 in bed. The surveyor observed the [redacted] had direct contact with the floor on the window side of the bed. A review of the medical record revealed Resident #18 had diagnoses which included but were not limited to; [redacted] A review of the Minimum Data Set (MDS), an assessment tool, dated [redacted], revealed that Resident #18 was identified as having an [redacted]. A review of the Physician's Orders dated 7/18/2022, included an order for [redacted] care every shift. During an interview with the surveyor on 10/17/22 at 11:01 AM, the Licensed Practical Nurse Unit Manager stated that the [redacted] should not be on the floor. During an interview with the surveyor on 10/17/22 at 11:43 AM, the Director of Nursing stated that a [redacted] should not be on the floor. A review of a facility [redacted] Protocol with a reviewed date of 1/2022, included: 10 [redacted] must not touch the floor or be placed above resident's [redacted]. NJAC 8:39-19:4(a) (1-6)	F 690	NJ Exec. Order 26:4.b.1 have the potential to be affected by this deficient practice. • Audits were conducted for all residents who have an NJ Exec. Order 26:4.b.1 NJ Exec. Order 26:4.b.1 to ensure the NJ Exec. Order 26:4.b.1 NJ Exec. Order 26:4.b.1 were not touching the floor. III. Measures will be put into place to ensure the deficient practice will not recur: • Licensed Nurses and Certified Nursing Assistants (C.N.A.'s) were re-educated by the Infection Preventionist/Designee on the facilities Indwelling NJ Exec. Order 26:4.b.1 protocol. • A new measure was implemented, the Infection Preventionist/Designee has added to the Infection Control Rounds Audit Tool observing that NJ Exec. Order 26:4.b.1 NJ Exec. Order 26:4.b.1 are not touching the floor. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: • Infection Preventionist /Designee will conduct weekly NJ Exec. Order 26:4.b.1 NJ Exec. Order 26:4.b.1 audits times 4 weeks, then monthly times 3 months to validate that NJ Exec. Order 26:4.b.1 bags are not touching the floor. Discrepancies will be reported to the Director of Nursing (DON) with follow up actions as necessary. • The DON will analyze and trend the NJ Exec. Order 26:4.b.1 Audit reports findings and report outcomes to the QA Committee quarterly for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315260	A. BUILDING ______ B. WING ______	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	**600 PEMBERTON BROWN MILLS RD PEMBERTON, NJ 08068**

(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 690	Continued From page 3	F 690	recommendations as necessary.	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060302	A. BUILDING: ______ B. WING ______	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	600 PEMBERTON BROWN MILLS RD PEMBERTON, NJ 08068

(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 000	Initial Comments 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 deficieny 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: 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. This was evident for 13 of 14-day shifts reviewed. 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	S 560	Corrective action(s)accomplished for resident(s)affected: " No residents were identified II. Residents identified having the potential to be affected and corrective action taken: " The deficient practice has the potential to affect all residents residing in the facility. III. Measures will be put into place to ensure the deficient practice will not recur: " The facility currently has 6 Nursing Agency contracts. " The daily bonus range has been	12/5/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 11/08/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060302	A. BUILDING: ______ B. WING ______	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	600 PEMBERTON BROWN MILLS RD PEMBERTON, NJ 08068

(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	Continued From page 1	S 560		

established minimum staffing requirements in nursing homes. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021:

One 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 09/18/2022-09/24/2022 and 09/25/2022 -10/01/2022, the staffing-to-resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift are documented below:

-09/18/22 had 14 CNAs for 170 residents on the day shift, required 21 CNAs.
-09/19/22 had 17 CNAs for 169 residents on the day shift, required 21 CNAs.
-09/21/22 had 18 CNAs for 169 residents on the day shift, required 21 CNAs.
-09/22/22 had 17 CNAs for 169 residents

reviewed and increased. Daily bonuses are offered for double shifts, extra shifts, weekend shifts and staff recognition.
" Referral and sign on bonuses are offered.
" The call out Policy has been reviewed and the staff has been re-educated
" Advertisements signs are placed by bus stops in front of the building.
1. Advertisements for available C.N.A. positions have been placed in the local newspaper.
" The facility is recruiting on multiple employment search engines and multiple social media platforms.
" Depending on the needs of the day Nursing management to include Unit Mangers, Supervisors and ADON will be evaluated to assist with resident care.
" Rates have been increased for C.N.As

IV. Corrective actions will be monitored to ensure the deficient practice will not recur:
" The DON/Designee will conduct weekly C.N.A. staffing schedule audits.
" The DON/Designee will report audit findings to the Administrator. The Administrator/Designee will analyze and trend findings and report outcomes quarterly to the QA Committee for the next meeting, with follow up to recommendations, as necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060302	A. BUILDING: ____ B. WING ____	10/26/2022

NAME OF PROVIDER OR SUPPLIER: **ASPEN HILLS HEALTHCARE CENTER**

STREET ADDRESS, CITY, STATE, ZIP CODE: **600 PEMBERTON BROWN MILLS RD, PEMBERTON, NJ 08068**

(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	Continued From page 2	S 560		

on the day shift, required 21 CNAs.
-09/23/22 had 21 CNAs for 173 residents on the day shift, required 22 CNAs.
-09/24/22 had 19 CNAs for 173 residents on the day shift, required 22 CNAs.
-09/25/22 had 16 CNAs for 172 residents on the day shift, required 21 CNAs.
-09/26/22 had 17 CNAs for 170 residents on the day shift, required 21 CNAs.
-09/27/22 had 18 CNAs for 170 residents on the day shift, required 21 CNAs.
-09/28/22 had 20 CNAs for 170 residents on the day shift, required 21 CNAs.
-09/29/22 had 16 CNAs for 170 residents on the day shift, required 21 CNAs.
-09/30/22 had 17 CNAs for 170 residents on the day shift, required 21 CNAs.
-10/01/22 had 16 CNAs for 172 residents on the day shift, required 21 CNAs.

During an interview with the surveyor on 10/11/22 at 09:28 AM, the Staffing Coordinator stated that the staff-to-resident ratios were 1:8 on day shift, 1:10 on evenings, and 1:14 on night shift. She further stated that the facility has used all resources to staff appropriately but acknowledged that the facility is still short at times.

During an interview with the surveyor on 10/18/2022 at 01:04 PM, the Director of Nursing (DON) said she is aware they (the facility) are short staffed. The DON also agreed that there is staffing shortage for CNA's.

A review of an undated facility policy titled Staffing Policy that included the following under the Policy section:

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060302	A. BUILDING: ____ B. WING ____	10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	600 PEMBERTON BROWN MILLS RD PEMBERTON, NJ 08068

(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	Continued From page 3 Certified nursing assistants will be available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan and with the following ratios: One certified nurse aide to every eight residents for the day. One direct care staff member to every ten residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each direct care staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties. One direct care staff member to every fourteen residents for the night shift, provided that each direct care staff member shall be signed in to work as a certified nurse aide and perform certified nurse aide duties.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315260	A. Building B. Wing	12/6/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	600 PEMBERTON BROWN MILLS RD PEMBERTON, NJ 08068

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 F0690 Reg. # 483.25(e)(1)-(3) LSC	Correction Completed 12/05/2022	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
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	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
10/26/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
060302		12/6/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	600 PEMBERTON BROWN MILLS RD PEMBERTON, NJ 08068

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 12/05/2022	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
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	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 10/26/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315260	A. BUILDING **01** B. WING ___________________________	**10/26/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	**600 PEMBERTON BROWN MILLS RD** **PEMBERTON, NJ 08068**

(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
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/25, 26/2022 and Aspen Hills healthcare Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Premeir Cadbury of Cherry Hill is a three story, Type II Protected building that was built in June 1985. The facility is divided into 19 smoke zones.	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A	K 321		12/5/22

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

Electronically Signed — 11/08/2022

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
	315260	A. BUILDING **01** B. WING ______	**10/26/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	**600 PEMBERTON BROWN MILLS RD** **PEMBERTON, NJ 08068**

(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
K 321	Continued From page 1 a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation on 10/25/2022 and 10/26/2022 in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice was evidenced by the following: On 10/25/2022 at 8:51 AM, a request was made to the Maintenance Director (MD)to provide a copy of the facility lay-out which identifies various rooms and smoke compartments. On 10/26/2022 in the presence of the facility Administrator, Corporate Maintenance (CM) and MD at 11:58 AM, an inspection on the Oak Court Unit (secured unit) was performed. This inspection identified at the nurses station a storage room that contained approximately 108 Banker size boxes filled with combustible Medical	K 321	I. Corrective action(s)accomplished for resident(s)affected: " The door leading into the storage room was repaired immediately and closes automatically in the door frame. II. Residents identified having the potential to be affected and corrective action taken: " All residents currently residing in the facility have the potential to be affected. " The Maintenance Director checked all doors leading to hazardous areas to ensure they closed automatically into the door frame. III. Measures will be put into place to ensure the deficient practice will not recur: " The Administrator educated the Maintenance Director regarding Doors to hazardous areas must close automatically into the door frame. " Maintenance staff were educated by the Director of Maintenance regarding Doors to hazardous areas must close	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315260	A. BUILDING **01** B. WING ______	**10/26/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	**600 PEMBERTON BROWN MILLS RD** **PEMBERTON, NJ 08068**

(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
K 321	Continued From page 2 Records. A closure test of the corridor door was performed. When the door was opened to a 90 degree opening/angle to the doors frame and released, the door did not close into its frame leaving an approximately one (1) inch opening. This closure test was repeated two additional times with the same results. The room was approximately 20 feet by 12 feet (240 square feet) which is larger than 50 square feet. The door failed to self-close into its frame as required by code. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. The CM and MD confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 10/26/2022 at approximately 1:30 PM. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321	automatically into the door frame. " Maintenance staff will be educated upon orientation and periodically thereafter regarding Doors to hazardous areas must close automatically into the door frame. " The Maintenance staff will audit all doors leading to hazardous areas on a weekly basis to ensure they close automatically into the door frame. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: " The Maintenance Director /Designee will conduct monthly audits times 5 months to ensure all doors leading to hazardous areas basis close automatically. " The Maintenance Director will report any issues to the Administrator with follow up actions as necessary. " The Administrator/Designee will analyze and trend findings from the audits and report outcomes quarterly to the QA Committee for the next 2 meetings, with follow up to recommendations as necessary.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.	K 351		12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315260	A. BUILDING **01** B. WING ___	**10/26/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	**600 PEMBERTON BROWN MILLS RD** **PEMBERTON, NJ 08068**

(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
K 351	Continued From page 3 In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 10/26/2022, it was determined the facility failed to provide proper fire sprinkler coverage to all areas of the facility, as required by National Fire Protection Association (NFPA) 13 for Installation of Sprinkler Systems. This deficient practice was evidenced by the following, On 10/25/2022 (day one of survey) at 8:51 AM, a request was made to the Maintenance Director (MD)to provide a copy of the facility lay-out which identifies various rooms and smoke compartments. During the building tour on 10/26/2022 (day two of survey) in the presence of the facility's Administrator, Corporate Maintenance and MD, the surveyor observed the following location that failed to have proper fire sprinkler protection; 1. At 12:46 PM, the surveyor observed no	K 351	I. Corrective action(s)accomplished for resident(s)affected: " No residents were identified to have had any negative impact from this deficient practice. " The drop ceiling that was obstructing the sprinkler head was immediately removed. II. Residents identified having the potential to be affected and corrective action taken: " All residents currently residing in the facility have the potential to be affected. " The Maintenance Director audited all areas of the facility to ensure that the sprinkler heads were not obstructed and that there was proper fire sprinkler coverage to all areas of the facility as required. III. Measures will be put into place to ensure the deficient practice will not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315260	A. BUILDING **01** B. WING ______	**10/26/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	**600 PEMBERTON BROWN MILLS RD** **PEMBERTON, NJ 08068**

(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
K 351	Continued From page 4 evidence of fire sprinkler protection inside the approximately 4 feet by 7 feet first floor telephone/ communication room near the front lobby area. At that time the surveyor asked the MD, do you see a fire sprinkler inside the room. The MD looked up inside the room and said, No. The CM and MD confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 10/26/2022 at approximately 1:30 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351	recur: " The Administrator educated the Maintenance Director regarding the importance of not obstructing sprinkler heads and ensuring proper fire sprinkler coverage to all areas of the facility as required. " Maintenance staff were educated by the Director of Maintenance regarding the importance of not obstructing sprinkler heads and ensuring proper fire sprinkler coverage to all areas of the facility as required. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: " The Director of Maintenance/Designee will conduct weekly audits times four weeks and then monthly audits for 5 months of the sprinkler system ensuring that nothing is obstructing the sprinkler heads and proper fire sprinkler coverage to all areas of the facility as required. A quarterly, inspection is also conducted by the facility fire sprinkler vendor to ensure the function and maintenance of the fire automatic fire sprinkler system. " The Maintenance Director will report any issues to the Administrator with follow up actions as necessary. " The Administrator/Designee will analyze and trend findings from the audits and report outcomes quarterly to the QA Committee for the next 2 meetings, with follow up to recommendations as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315260	A. BUILDING **01** B. WING	**10/26/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	**600 PEMBERTON BROWN MILLS RD** **PEMBERTON, NJ 08068**

(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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315260	A. Building 01 - MAIN BUILDING 01 B. Wing	12/6/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	600 PEMBERTON BROWN MILLS RD PEMBERTON, NJ 08068

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 Reg. # NFPA 101 LSC K0321	Correction Completed 12/05/2022	ID Prefix Reg. # NFPA 101 LSC K0351	Correction Completed 12/05/2022	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	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
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
10/26/2022	