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 _____	C 05/03/2022

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 000	INITIAL COMMENTS COMPLAINT#: NJ152051, NJ152957, NJ154266 CENSUS: 169 SAMPLE SIZE: 3 THE FACILITY IS NOT 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		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: C#: NJ154266 Based on interviews, medical record reviews, and reviews of other pertinent facility documents on 5/3/2022, it was determined that the facility failed to provide a resident with *Ex Order 26. 4B1* [redacted] staff assistance needed to meet the Resident's needs at an appointment. This deficient practice was identified for 1 of 3 residents (Resident #3) reviewed and was evidenced by the following: Review of Resident #3's Electronic Medical	F 558	I. Corrective action(s)accomplished for resident(s)affected: • The identified Licensed Nurse was re-educated regarding providing staff assistance to meet the resident's needs at appointments. • Resident #3's physician was notified, and this resident had no negative outcomes related to this deficient practice. The appointment was rescheduled for *Ex Order 26. 4B1* with an escort. The resident was uncooperative and refused to be examined.	6/13/22

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

Electronically Signed | 05/25/2022

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
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F 558	Continued From page 1 Record (EMR) was as follows: According to the "Admission Record," Resident #3 was admitted to the facility on Ex Order 26. 4B1 with diagnoses which included, but were not limited to, Ex Order 26. 4B1 [redacted]. According to the Admission Minimum Data Set (MDS) dated Ex Order 26. 4B1, Resident #3's ability to express ideas and wants is sometimes understood. The Resident sometimes understands and adequately responds to simple, direct communication only. Further review of the MDS revealed that Resident #3 needed Ex Order 26. 4B1 [redacted] and Ex Order 26. 4B1 [redacted] with transfers, toileting, and personal hygiene. The MDS also showed Resident #3 was Ex Order 26. 4B1 [redacted] and needed staff assistance with balance during transitions and walking. A review of Resident #3's Physician Progress Note (PPN) dated Ex Order 26. 4B1 at 2:44 p.m. revealed the Resident was admitted to the facility for Ex Order 26. 4B1 [redacted]. A review of Resident #3's Progress Notes dated Ex Order 26. 4B1 at 2:26 p.m. written by the Licensed Practice Nurse (LPN) revealed that the Resident was picked up by transport for a follow-up Ex Order 26. [redacted] appointment at 11:25 a.m. and	F 558	II. Residents identified having the potential to be affected and corrective action taken: • Residents currently residing in the facility have the potential to be affected. • All residents that had appointments scheduled were reviewed to ensure that staff assistance was provided to meet the resident's needs. III. Measures will be put into place to ensure the deficient practice will not recur: • When scheduling appointments, a new process has been put into place regarding providing staff assistance to meet the resident's needs at appointments. This process will evaluate multiple areas that may be barriers for safe and cooperative care by the resident so that he/she can receive care at medical appointments when feasible. • Unit managers, Licensed Nurses and the staffing coordinator were re-educated by the Assistant Director of Nursing (ADON)/Designee regarding providing staff assistance to meet the resident's needs at appointments. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: • ADON/Designee will conduct a weekly audit times 4 weeks, then monthly times 3 months to validate that staff assistance has been provided to meet the resident's needs at appointments. Discrepancies will be reported to the Director of Nursing (DON) with follow up actions as necessary.	

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F 558	Continued From page 2 remained out at this time. A review of the Assignment Sheet dated Ex Order 26. 4B1 revealed the appointment was listed, but no staff name was listed to accompany the Resident to the appointment. A review of the "April Transportation Log (ATL)" revealed a Date of Ex Order 26. 4B1, under "Resident," showed Resident #3's name with Appt. (Appointment) Type as Ex Order 26. 4B1, and under the column titled "Escort (staff)," revealed a blank space. During an interview on 5/3/2022 at 2:08 p.m. with Resident #3, when the surveyor asked the resident direct questions, the Resident could not answer the questions accurately and would reply, "Ex Order 26. 4" and "Ex Order 26. 4B1." During an interview on 5/3/2022 at 2:19 p.m., the LPN assigned to Resident #3 on Ex Order 26. 4B1 the surveyor asked if the Resident needed staff to accompany him/her on an appointment; she stated the Resident definitely needed someone to go with him/her. The LPN further said the process is the Unit Secretary communicated with the Staffing Coordinator, and she scheduled what staff would go on the appointment with the Resident. She explained she reminded the Staffing Coordinator in the morning that the person (Resident) needed an aide (Certified Nursing Assistant, CNA). The LPN said as the nurse; it is my responsibility to make sure staff goes with the Resident, and I would remind the Staffing Coordinator that morning of the appointment. During a second interview on 5/3/2022 at 2:25	F 558	• The DON will analyze and trend the Appointment Audit Reports findings and report outcomes to the QA Committee quarterly for recommendations as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 558	Continued From page 3 p.m., when the surveyor asked the LPN if Resident #3 had staff go on the [redacted] appointment with him/her, the LPN replied, "I can't remember if staff went with (him/her)." She further stated that Resident #3 would not be able to answer questions during an appointment, the Resident talks about his/her mom, and it would not be safe for Resident #3 to go to the appointment alone. During an interview on 5/3/2022 at 4:09 p.m., the Director of Rehabilitation/ Physical Therapist stated that Resident #3 is not able to transfer without assistance and needs physical assistance to perform functional mobility and [redacted]. When the surveyor asked him if it was unsafe for Resident #3 to go to a doctor's (physician) appointment alone, he replied, "Oh yes, for safety, he/she should have an escort" the Resident needs supervision. The DOR/PT continued to say that Resident #3 needed verbal cueing to perform proper technique and sequencing of tasks for safety. When the surveyor asked him if Resident #3 could answer questions, he stated not coherently; the Resident did not make sense. During an interview on 5/3/2022 at 5:10 p.m., the Director of Nursing (DON) stated the Assignment Sheet would be noted for the appointment with an escort, but since there is no name listed, Resident # 3 did not have an escort. It was decided on a case-by-case basis if a resident needed an escort for an appointment. When the surveyor showed her the ATL, the DON stated since the column titled "Escort" was blank, Resident #3 did not have an escort. During a post-survey telephone interview on	F 558		

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F 558	Continued From page 4 5/5/2022 at 8:25 a.m., the Physician Assistant (PA) at the Ex Order 26. 4B1 appointment on Ex Order 26. 4B1 stated that when Resident #3 was brought to her examination room, the Resident came unassisted by the facility staff and would not cooperate during the Ex Order 26. 4. The Resident could not communicate and kept saying "Ex Order 26. 4B1" repetitively. When I tried to examine the incision, she stated that the Resident had his/her hands up, wouldn't let the PA examine him /her, and was scared, so I stopped the examination. It was my first meeting with the Resident. The PA further stated she did not know Resident #3's mobility status because no Ex Order 26. 4B1 was sent with the Resident. During a post-survey telephone interview on 5/9/2022 at 8:42 a.m., the Office Supervisor/Assistant Operations Manager (OS/AOM) at the Ex Order 26. 4B1 appointment on Ex Order 26. 4B1 stated that Resident #3 was dropped off by transport and alone. Transport said to her that the Resident was not cooperative. The Resident had a 1:00 p.m. appointment. She further stated Resident #3 could not communicate his/her needs to staff. The OS/AOM said she told the Resident that Ex Order 26. 4 staff would be with him/her soon, but the Resident had no response. At 2:45 p.m., she did speak with the nurse, and she informed her that Resident #3 needed staff with him/her. The OS/AOM further stated that Resident #3 was scared, complained, shouted, "Ex Order 26. 4B1," and refused the Ex Order 26. 4 and examination, so the appointment was not done, and the facility was made aware. During a post-survey telephone interview on 5/9/2022 at 11:20 a.m. with the Ex Order 26. 4 Supervisor	F 558		

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F 558	Continued From page 5 at the Ex Order 26. 4B1 appointment on Ex Order 26. 4B1, she stated Resident #3 was confused, scared, and didn't understand what needed to get done. Resident #3 was unable to communicate and stayed in the wheelchair the whole time. We locked the wheelchair; the Resident could not do it him/herself. We didn't know his/her mobility. She further stated that Resident #3 pushed me out of the way, so we stopped. The Ex Order 26. 4 was unable to be completed. The facility failed to ensure that Resident #3 had facility staff assistance at the Ex Order 26. 4B1 appointment on 4/18/2022. N.J.A.C.: 8:39-27.1 (a)	F 558		

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 _____	C 05/03/2022

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

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S 000	Initial Comments 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: C#: NJ152051, NJ152957, NJ154266 Based on interviews and facility document review, it was determined that the facility failed to ensure staffing ratios were met for 20 shifts of 21 shifts reviewed. There had been no increase in the resident census for a period of nine consecutive shifts. This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health	S 560	I. 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:	6/13/22

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

Electronically Signed — 05/25/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HILLS HEALTHCARE CENTER	600 PEMBERTON BROWN MILLS RD PEMBERTON, NJ 08068

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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 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 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. 1. For the 2 weeks from 01/23/2022 to 02/05/2022, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: On 01/24/22 had 20 CNAs for 175 residents on the day shift, required 22 CNAs On 01/25/22 had 18 CNAs for 175 residents on the day shift, required 22 CNAs. On 1/26/22 had 18 CNAs for 175 residents on the day shift, required 22 CNAs. On 01/27/22 had 19 CNAs for 177 residents on the day shift, required 22 CNAs. On 01/28/22 had 19 CNAs for 177 residents on the day shift, required 22 CNAs. On 01/29/22 had 13 CNAs for 177 residents on the day shift, required 22 CNAs. On 01/30/22 had 15 CNAs for 177 residents on	S 560	• The facility currently has 6 Nursing Agency contracts. • The daily bonus range has been 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 _____	C 05/03/2022

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S 560	Continued From page 2 the day shift, required 23 CNAs. On 01/31/22 had 20 CNAs for 180 residents on the day shift, required 23 CNAs. On 02/01/22 had 22 CNAs for 180 residents on the day shift, required 23 CNAs. On 02/02/22 had 22 CNAs for 177 residents on the day shift, required 23 CNAs. On 02/03/22 had 17 CNAs for 176 residents on the day shift, required 22 CNAs. On 02/04/22 had 20 CNAs for 176 residents on the day shift, required 22 CNAs. On 02/05/22 had 19 CNAs for 176 residents on the day shift, required 22 CNAs. 2. For the week from 04/17/2022 to 04/23/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: On 04/17/22 had 16 CNAs for 171 residents on the day shift, required 22 CNAs. On 04/18/22 had 16 CNAs for 171 residents on the day shift, required 22 CNAs. On 04/19/22 had 17 CNAs for 171 residents on the day shift, required 22 CNAs. On 04/20/22 had 19 CNAs for 171 residents on the day shift, required 22 CNAs. On 04/21/22 had 18 CNAs for 171 residents on the day shift, required 22 CNAs. On 04/22/22 had 17 CNAs for 171 residents on the day shift, required 22 CNAs. On 04/23/22 had 16 CNAs for 171 residents on the day shift, required 22 CNAs.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315260 (Y1)	A. Building B. Wing (Y2)	6/13/2022 (Y3)

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 F0558 Reg. # 483.10(e)(3) LSC	Correction Completed 06/13/2022	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
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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	
5/3/2022	☐ 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 (Y2)	DATE OF REVISIT (Y3)
060302	A. Building B. Wing	6/13/2022

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 06/13/2022	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
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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 5/3/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			