STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061004	A. BUILDING: _____ B. WING _____	07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS CARE CENTER	16 CRATETOWN ROAD LEBANON, NJ 08833

(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, 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: Based on interviews, and facility document review, the facility failed to ensure staffing ratios were met for 5 of 15 shifts reviewed. There was no substantial 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 (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,	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: " The facility currently has 7 Nursing Agency contracts.	8/27/21

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

Electronically Signed | 08/05/21

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	061004	A. BUILDING: _____ B. WING _____	07/23/2021

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S 560	Continued From page 1 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. On 7/19/21, the day shift staffing ratio was one CNA to 11 residents. On 7/20/21 and 7/21/21, the day shift staffing ratio was one CNA to 9 residents. The minimum staffing ratio for day shift is one CNA to eight residents. On 7/21/21 and 7/22/21, the night shift staffing ratio was one CNA to 19 residents. The minimum staffing ratio for night shift is one CNA to 14 residents. On 7/23/21 at 9:30 AM, the surveyor interviewed the Staffing Coordinator. She stated that she was aware of the new minimum staffing requirements and the facility is currently attempting to hire new CNAs. On 7/23/21 at 10:25 AM, the surveyor discussed the staffing ratios concerns with the Administrator and Director of Nursing, who stated the facility is	S 560	" Daily bonuses are offered for double shifts, extra shifts, weekend shifts and staff recognition as needed. " 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 in front of the building. " 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 Director of Nursing (DON), Mangers, Supervisors and Assistant Director of Nursing (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 Director of Nursing - DON/Designee will conduct weekly C.N.A. staffing schedule audits. " The Director of Nursing - 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.	

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S 560	Continued From page 2 attempting to hire new 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
315302 Y1	A. Building B. Wing Y2	7/15/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS CARE CENTER	16 CRATETOWN ROAD LEBANON, NJ 08833

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 F0273 Reg. # 483.20(b)(2)(i) LSC	Correction Completed 07/15/2017	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	
6/1/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO