STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315213	A. BUILDING _____ B. WING _____	C 11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS REHABILITATION AND HEALTHCARE CTR	**1049 BURNT TAVERN ROAD BRICK, NJ 08724**

(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 #: NJ00166191, NJ00166428 Census: 127 Sample Size: 4 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 SURVEY.	F 000		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842		11/22/23

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

Electronically Signed | 11/29/2023

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.

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F 842	Continued From page 1	F 842		

records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and

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F 842	Continued From page 2 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00166428 Based on interviews, medical record review, and review of other pertinent facility documents on 11/02/23 and 11/03/23, it was determined that the facility staff failed to consistently document on the "Documentation Survey Report" the Activities of Daily Living (ADL) status and care provided to the resident. The deficient practice was identified for Resident [redacted] 1 of 4 residents reviewed for documentation and was evidenced by the following: The surveyor reviewed the closed record for Resident [redacted] According to the Admission Record, Resident #1 was admitted [redacted], with medical diagnoses that included but were not limited to [redacted]. The admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed a Brief Interview of Mental Status score of [redacted] which indicated the resident's cognition [redacted]. The MDS also indicated the resident required setup to maximal assistance for ADLs. Review of Resident [redacted]'s care plan revealed a "Focus" of ADL Self Care Performance Deficit	F 842	1. Resident Records-Identifiable Information The medical record of Resident [redacted].Resident no longer resides in the facility. All nursing staff, have been reeducated on proper required Activity of Daily Living task charting and documentation in the Residents medical record . 2. All Residents of the facility have the potential to be affected by incomplete ADL task documentation. 3. -Certified Nursing assistants were in-serviced by staff educator on 11/22/2023 regarding completion of ADL documentation prior to end of their shift. -Nurses were reeducated by staff educator on 11/22/2023 to ensure the Certified nursing assistants complete documentation prior to end of shift. -Nursing Supervisor will audit Point Of Care documentation prior to end of each shift to ensure certified nursing assistants complete documentation on all residents. -Unit Manager will review POC documentation during morning clinical to ensure the documentation is completed for previous day. 4. -The Director of Nursing or designee will audit the POC documentation for 10 residents weekly for 4 weeks and then Monthly x 2 months to ensure 100% compliance of POC Documentation. - The	

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F 842	Continued From page 3 related to NJ EX Order. 264b1 related to NJ EX Order. 264b1 process. The care plan was initiated on NJ EX Order. 264b1 and indicated that the resident required between NJ EX O staff members to assist them with ADLs. Review of Resident # NJ EX "Documentation Survey Report v2" form (DSR) (a form that documents the ADL care provided by the Certified Nursing Assistants (CNAs)) for July 2023 revealed blank spaces indicating the tasks were not completed as follows: Bathing, Boosting up in Bed/ Wheelchair, Dressing, and Personal Hygiene on 07/02/23 on the day shift, on 07/05/23 on the evening shift, on 07/02/23, 07/03/23, 07/05/23, and 07/06/23 on the night shift. Bed Mobility, Bladder Continence, and Preventative Skin Care with Moisture Barrier after each incontinence episode on 07/02/23 on the day shift, on 07/03/23 and 07/05/23 on the evening shift, on 07/02/23, 07/03/23, 07/05/23, and 07/06/23 on the night shift. Bowel Continence, Bowel Movements, and CNA Skin Check on 07/05/23 on the evening shift, on 07/02/23, 07/03/23, 07/05/23, and 07/06/23 on the night shift. Mobility/ Locomotion on 07/02/23 and 07/04/23 on the day shift, on 07/05/23 on the evening shift, on 07/02/23, 07/03/23, 07/05/23, and 07/06/23 on the night shift. Mobility: Lying to Sitting/Sitting to Lying, and Toilet Use on 07/02/23 and 07/04/23 on the day shift, on 07/05/23 on the evening shift, on 07/02/23,	F 842	results of the audits will be reviewed during the monthly Quality Assurance and Performance Improvement Committee meeting. - The QAPI Committee will make recommendations based upon the results of the audits - The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved.	

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F 842	Continued From page 4 07/03/23, and 07/06/23 on the night shift. Mobility/Locomotion off Unit, Mobility/ Locomotion on Unit/ in Hallway, Mobility: Boosting in Wheelchair, Mobility: Lifting Legs into Bed, Transferring, and Turning and Positioning on 07/02/23, 07/04/23 on the day shift, on 07/03/23 and 07/05/23 on the evening shift, on 07/02/23, 07/03/23, and 07/06/23 on the night shift. Amount Eaten at 5 PM, Eating at 5 PM, and Bedtime Snack at 9 PM on 07/05/23. During an interview with the surveyor on 11/03/23 at 11:44 AM, CNA #1 stated she remembered and took care of Resident #1 when they were in the facility. CNA #1 continued that Resident [redacted] was dependent on staff for ADL care and that on day shift they would help the resident get dress around 9:30 AM- 10:00 AM. CNA #1 added that Resident #[redacted]s ADL care should have been documented on the DSR three times a day, on all three shifts. CNA #1 stated the importance of ADL documentation was so everyone knew what care was provided for the resident. During an interview with the surveyor on 11/03/23 at 12:26 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated she remembered Resident #1 and that he/she was [redacted] on staff for ADL care. The LPN/UM further stated that the CNAs should have documented the ADL care for Resident [redacted] daily, on every shift. The LPN/UM added that the nurses, unit manager, and the administrator all checked to ensure ADL documentation was completed. During an interview with the surveyor on 11/03/23 at 12:45 PM, the Director of Nursing (DON)	F 842		

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F 842	Continued From page 5 stated Resident #1's ADL care including dressing should have been filled out every day and every shift by the CNAs. Review of the facility policy, "Activities of Daily Living (ADLs), Supporting" with a revised date of 03/18 revealed under the "Policy Interpretation and Implementation" section, "The resident's ability to participate in ADLs and the support provided during ADL care and resident-specific tasks will be documented each shift by Certified Nursing Assistants in the medical record." NJAC 8:39-35.2 (d)(6).	F 842		

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S 000	Initial Comments Complaint #: NJ00166191, NJ00166428 Census: 127 Sample Size: 4 The facility is 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 review of other facility documentation on 11/02/23 and 11/03/23 it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratio for the day shift as mandated by the State of New Jersey. The facility was deficient in Certified Nursing Assistants (CNA) staffing for residents on 35 of 35 day shifts. This deficient practice had the potential to affect all residents. Findings include:	S 560	No Residents were identified to be affected by this deficient practice. All Residents of the facility have the potential to be affected. Director of Nursing, Staffing Coordinator and Administrator will meet daily during the week to review recruitment efforts, staffing for next day, and staffing for upcoming week. Director of Nursing,	11/22/23

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

Electronically Signed | 11/29/23

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S 560	Continued From page 1 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 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) 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 (1) 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. As per the "Nurse Staffing Report" completed by the facility for the week of 05/14/2023 to 05/20/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -05/14/23 had 9 CNAs for 139 residents on the day shift, required at least 17 CNAs. -05/15/23 had 8 CNAs for 139 residents on the day shift, required at least 17 CNAs. -05/16/23 had 10 CNAs for 139 residents on the day shift, required at least 17 CNAs. -05/17/23 had 10 CNAs for 138 residents on the	S 560	Staffing Coordinator and Administrator will review projected staffing trends to accurately identify any potential shifts that will not met minimum staffing requirements. Bonus will be offered to existing staff and all contracted agencies will be contacted in an effort to fill the shifts . The facility has developed a Culture Committee focused on recruitment. and retention of staff along with customer service and the employee experience. The facility has implemented the Care Champion Program to mentor new employees which has been proven to raise retention rates. The facility participates in an interdisciplinary Quality Care Resource call to review open positions, recruitment tactics, and changes to improve outcomes. Contract staff utilization is reviewed bi- weekly to identify trends and opportunities. The facility has contracts in place with multiple staffing agencies as an effort to provide additional staff when needed. The facility has acquired housing to help with lodging for staff if needed. The facility has implemented a multifaceted approach for recruitment and retention of employees, Job fairs, Flexible scheduling, walk in interviews, hire upon walk in. Increased utilization of PRN staff, Multimedia advertisements, Partnership with schools, Sign on bonuses, Referral bonuses, Pick-up shift bonuses, Boomerang campaign to rehire staff that have resigned, Rate adjustments, Benefit adjustments, Contract staff utilization, Text message campaigns.	

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S 560	Continued From page 2 day shift, required at least 17 CNAs. -05/18/23 had 11 CNAs for 137 residents on the day shift, required at least 17 CNAs. -05/19/23 had 9 CNAs for 137 residents on the day shift, required at least 17 CNAs. -05/20/23 had 9 CNAs for 137 residents on the day shift, required at least 17 CNAs. 2. As per the "Nurse Staffing Report" completed by the facility for the week of 07/02/2023 to 07/08/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -07/02/23 had 11 CNAs for 129 residents on the day shift, required at least 16 CNAs. -07/03/23 had 12 CNAs for 129 residents on the day shift, required at least 16 CNAs. -07/04/23 had 12 CNAs for 129 residents on the day shift, required at least 16 CNAs. -07/05/23 had 13 CNAs for 129 residents on the day shift, required at least 16 CNAs. -07/06/23 had 11 CNAs for 131 residents on the day shift, required at least 16 CNAs. -07/07/23 had 10 CNAs for 131 residents on the day shift, required at least 16 CNAs. -07/08/23 had 9 CNAs for 131 residents on the day shift, required at least 16 CNAs. 3. As per the "Nurse Staffing Report" completed by the facility for the week of 07/16/2023 to 07/22/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -07/16/23 had 11 CNAs for 133 residents on the day shift, required at least 17 CNAs. -07/17/23 had 11 CNAs for 133 residents on the day shift, required at least 17 CNAs. -07/18/23 had 8 CNAs for 133 residents on the	S 560	The director of Nursing will monitor staffing daiy x5, weekly x4,and monthky x3,to maintain ongoing staffing compliance, results of the audits will be reviewed monthly with the Quality Assurance and Performance Improvement committee until substantial compliance is met . The results of Resident Council minutes as well as recruitment data will be reviewed by the Administrator or designee at the quarterly QAPI meeting.	

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S 560	Continued From page 3 day shift, required at least 17 CNAs. -07/19/23 had 10 CNAs for 133 residents on the day shift, required at least 17 CNAs. -07/20/23 had 11 CNAs for 136 residents on the day shift, required at least 17 CNAs. -07/21/23 had 11 CNAs for 136 residents on the day shift, required at least 17 CNAs. -07/22/23 had 7 CNAs for 136 residents on the day shift, required at least 17 CNAs. 4. As per the "Nurse Staffing Report" completed by the facility for the weeks of 10/15/2023 to 10/28/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -10/15/23 had 14 CNAs for 124 residents on the day shift, required at least 15 CNAs. -10/16/23 had 12 CNAs for 124 residents on the day shift, required at least 15 CNAs. -10/17/23 had 11 CNAs for 124 residents on the day shift, required at least 15 CNAs. -10/18/23 had 12 CNAs for 124 residents on the day shift, required at least 15 CNAs. -10/19/23 had 12 CNAs for 124 residents on the day shift, required at least 15 CNAs. -10/20/23 had 8 CNAs for 124 residents on the day shift, required at least 15 CNAs. -10/21/23 had 11 CNAs for 124 residents on the day shift, required at least 15 CNAs. -10/22/23 had 11 CNAs for 124 residents on the day shift, required at least 15 CNAs. -10/23/23 had 10 CNAs for 124 residents on the day shift, required at least 15 CNAs. -10/24/23 had 10 CNAs for 124 residents on the day shift, required at least 15 CNAs. -10/25/23 had 10 CNAs for 123 residents on the day shift, required at least 15 CNAs. -10/26/23 had 11 CNAs for 123 residents on the	S 560		

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S 560	Continued From page 4 day shift, required at least 15 CNAs. -10/27/23 had 11 CNAs for 123 residents on the day shift, required at least 15 CNAs. -10/28/23 had 11 CNAs for 123 residents on the day shift, required at least 15 CNAs.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061518 Y1	A. Building B. Wing Y2	12/1/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS REHABILITATION AND HEALTHCARE CTR	1049 BURNT TAVERN ROAD BRICK, NJ 08724

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 11/22/2023	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 11/3/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO

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)
315213	A. Building B. Wing	12/1/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS REHABILITATION AND HEALTHCARE CTR	1049 BURNT TAVERN ROAD BRICK, NJ 08724

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 F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 11/22/2023	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
11/3/2023

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