STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315200	A. BUILDING _____ B. WING _____	C 10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT PARKSIDE	**400 W STIMPSON AVE LINDEN, NJ 07036**

(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#: NJ 149407, NJ 148909 and NJ 147668 A Focused Infection Control and Complaint survey was conducted on behalf of the State of New Jersey Department of Health. THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS INFECTION CONTROL AND COMPLAINT SURVEY. Survey Dates: 10/11/2023 to 10/12/2023 Survey Census: 172 Sample Size: 10	F 000		

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

Electronically Signed | 11/06/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062017	A. BUILDING: _____ B. WING _____	C 10/12/2023

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ARISTACARE AT PARKSIDE	400 W STIMPSON AVE LINDEN, NJ 07036

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S 000	Initial Comments Complaint#: NJ 149407, NJ 148909 and NJ 147668 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 pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 13 of 14 day shifts as follows: 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	S 560	All residents are potentially affected by this practice. Sign on with new agencies Offer agency staff bonuses Offer our staff bonuses New retention and recruitment plan Job Fair Posting new ads around town and via social media Referral bonuses for our staff Referral bonuses for community Sign on bonus Sending new NAs to school sponsored by	11/6/23

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

Electronically Signed | 11/06/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062017	A. BUILDING: _____ B. WING _____	C 10/12/2023

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ARISTACARE AT PARKSIDE	400 W STIMPSON AVE LINDEN, NJ 07036

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S 560	Continued From page 1 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. As per the "Nurse Staffing Report" completed by the facility for the 2 weeks of staffing from 09/24/2023 to 10/07/2023, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below: 1. For the 2 weeks of staffing prior to survey from 09/24/2023 to 10/07/2023, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -09/24/23 had 19 CNAs for 175 residents on the day shift, required at least 22 CNAs. -09/25/23 had 15 CNAs for 175 residents on the day shift, required at least 22 CNAs. -09/26/23 had 19 CNAs for 175 residents on the day shift, required at least 22 CNAs. -09/27/23 had 14 CNAs for 175 residents on the day shift, required at least 22 CNAs. -09/28/23 had 15 CNAs for 170 residents on the	S 560	us The don to have weekly meetings with staffing coordinator to determine upcoming schedules to anticipate needs. The DON/designee will report findings to the administrator. The DON/designee will aggregate findings from these rounds monthly and review the findings with the administrator quarterly on an ongoing basis the DON/designee will provide a report of his/her findings to the QA committee for action as appropriate.	

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S 560	Continued From page 2 day shift, required at least 22 CNAs. -09/29/23 had 17 CNAs for 179 residents on the day shift, required at least 22 CNAs. -09/30/23 had 18 CNAs for 179 residents on the day shift, required at least 22 CNAs. -10/01/23 had 17 CNAs for 179 residents on the day shift, required at least 22 CNAs. -10/02/23 had 11 CNAs for 178 residents on the day shift, required at least 22 CNAs. -10/03/23 had 20 CNAs for 177 residents on the day shift, required at least 22 CNAs. -10/04/23 had 16 CNAs for 175 residents on the day shift, required at least 22 CNAs. -10/06/23 had 18 CNAs for 173 residents on the day shift, required at least 22 CNAs. -10/07/23 had 18 CNAs for 173 residents on the day shift, required at least 22 CNAs.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
062017 Y1	A. Building B. Wing Y2	11/14/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT PARKSIDE	400 W STIMPSON AVE LINDEN, NJ 07036

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 11/06/2023	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
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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	
10/12/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

EVENT ID: Y0GF12