	-	ID HUMAN SERVICES			FOF	RM APPROVED
		MEDICAID SERVICES				NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		315196	B. WING		1	C 1/02/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ARISTAC	ARE AT MANCHESTER			1770 TOBIAS AVENUE MANCHESTER, NJ 08759		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	o		
	Complaint #: NJ1461	180 and NJ147873				
	Census: 138					
	Sample Size: 8					
	of 42 CFR Part 483,	liance with the requirements Subpart B, for Long Term on this complaint survey.				
	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE 11/26/2021

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.

PRINTED: 08/01/2022

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 61517			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING	C 11/02/2021			
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
RISTACA	RE AT MANCHESTER		BIAS AVENUE	_		
			ESTER, NJ 0875			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLE	
S 000	Initial Comments		S 000			
	Complaint #: NJ1461	80 and NJ147873				
	Census: 138					
	Sample Size: 8					
	TYPE OF SURVEY: Complaint Survey					
	all the standards in th	ubstantial compliance with ne New Jersey Administrative s for Licensure of Long-Term				
	including a completio and ensure that the p to correct deficiencies action in accordance	mit a plan of correction, n date for each deficiency plan is implemented. Failure s may result in enforcement with provisions of New e Code Title 8, Chapter 43E, nsure Regulations.				
S 560	8:39-5.1(a) Mandator	ry Access to Care	S 560		12/3/21	
	(a) The facility shall c Federal, State, and lo regulations.	comply with applicable ocal laws, rules, and				
		is not met as evidenced				
	by: Intake #NJ147873			1. Proactive review of the staffing schedule for the next two weeks throug	ah	
	and New Jersey Dep memo, dated 01/28/2 the facility failed to er	facility document review, artment of Health (NJDOH) 2021, it was determined that nsure staffing ratios were		the next month. Nursing Administration was assigned to work on the units whe needed.	re	
	deficient in total staff	s reviewed. The facility was for residents for four of 35 wed. This deficient practice		2. All residents have the potential to be affected.	2	

Electronically Signed

STATE FORM

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If continuation sheet 1 of 5

11/26/21

New Jersey Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 61517		(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WING	C 11/02/2021			
			DDRESS, CITY, ST	ATE, ZIP CODE		
	RE AT MANCHESTER	MANCHI	ESTER, NJ 087	59		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE COMPLE	
S 560	Continued From page	e 1	S 560			
	had the potential to affect all residents.			3. Rates have been significantly inc for CNA's and licensed/registered n		
	Findings included:			staff.		
	(NJDOH) memo, date	ey Department of Health ed 01/28/2021, "Compliance		Recruitment ads were updated to re increases.	eflect	
	30:13-18, new minim	ersey Statutes Annotated) um staffing requirements for cated the New Jersey law P.L. 2020 c 112,		Banners are put by the facility to ad our openings and need for more sta		
	codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were			Agency contracts reviewed.	ad and	
	effective on 02/01/20			The call out policy has been reviewed the staff reeducated		
	One certified nurse a for the day shift.	id to every eight residents		Staffing policy updated to reflect sta mandate.	affing	
		ning shift, provided that no staff members shall be		The DON will have weekly meetings determine upcoming schedules to anticipate needs.	s to	
	member shall be signed in to work as a certified nurse aide and shall perform nurse aide duties; and			4. The DON/designee will report find to the Administrator. The DON/designee will aggregate find	indings	
	direct care staff mem certified nurse aide a	member to every 14 t shift, provided that each ber shall sign in to work as a nd perform certified nurse		from these rounds monthly and revi findings with the Administrator/desig Monthly on an ongoing basis the DON/designee will provide a report findings to the QAPI committee for a	of	
	aide duties. 1. On 11/05/2021 at 5	5:02 PM, the Nursing Home		as appropriate.		
	Administrator (NHA) facility's staffing inform	provided copies of the mation for the survey day gust of 2021. A review of the				
	facility's staffing inform	mation provided by the NHA s staffing did not conform				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C	
	61517		B. WING	······	11	/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ARISTAC	ARE AT MANCHESTER		BIAS AVENUE			
	1		ESTER, NJ 08759			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S 560	Continued From page	2	S 560			
	A review of the "Nurs completed by the faci 08/01/2021 to 09/04/2 staff-to-resident ratios minimum requiremen 08/01/2021: 11 CNAs day shift; 20 CNAs re 08/01/2021: Nine tota the overnight shift; 11 08/03/2021: 17 CNAs day shift; 19 CNAs re 08/06/2021: 17 CNAs day shift; 19 CNAs re 08/07/2021: 14 CNAs day shift; 19 CNAs re 08/08/2021: 11 CNAs day shift; 20 CNAs re 08/09/2021: 16 CNAs day shift; 20 CNAs re 08/10/2021: 18 CNAs day shift; 20 CNAs re 08/12/2021: 15 CNAs day shift; 19 CNAs re 08/13/2021: 14 CNAs day shift; 19 CNAs re 08/12/2021: 14 CNAs day shift; 19 CNAs re 08/13/2021: 14 CNAs day shift; 19 CNAs re 08/14/2021: 14 CNAs day shift; 19 CNAs re 08/14/2021: 10 total s overnight shift; 11 tota 08/15/2021: Nine CNA day shift; 19 CNAs re 08/16/2021: 17 CNAs day shift; 19 CNAs re	e Staffing Report," lity for the weeks from 2021, revealed a that failed to meet the ts as listed below: for 153 residents on the quired a staff for 153 residents on total staff required a for 151 residents on the quired a for 154 residents on the quired a for 154 residents on the quired a for 149 residents on the quired b for 149 residents on the quired c for 149 residents on the quired a for 149 residents on the quired b for 149 residents on the quired c for 149 residents on the c for 151				
	day shift; 19 CNAs re 08/18/2021: 17 CNAs day shift; 19 CNAs re	quired for 149 residents on the quired for 145 residents on the				

New Jersey Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 61517		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C 11/02/2021	
		B. WING				
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		1770 TO	BIAS AVENUE			
ARISTAC	ARE AT MANCHESTER	MANCHI	ESTER, NJ 08759			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S 560	Continued From page	23	S 560			
	day shift; 18 CNAs re 08/21/2021: 13 CNAs day shift; 18 CNAs re 08/21/2021: Nine tota the overnight shift; 11 08/22/2021: 11 CNAs day shift; 18 CNAs re 08/22/2021: 10 total s day shift; 11 total staf 08/23/2021: 15 CNAs day shift; 18 CNAs re 08/24/2021: 16 CNAs day shift; 18 CNAs re 08/26/2021: 15 CNAs day shift; 18 CNAs re 08/26/2021: 13 CNAs day shift; 18 CNAs re 08/28/2021: 14 CNAs day shift; 18 CNAs re 08/29/2021: 14 CNAs day shift; 18 CNAs re 08/29/2021: 11 CNAs day shift; 18 CNAs re 08/29/2021: 15 CNAs day shift; 17 CNAs re 08/31/2021: 15 CNAs day shift; 17 CNAs re	for 143 residents on the quired al staff for 143 residents on total staff required for 143 residents on the quired staff for 143 residents on the frequired for 143 residents on the quired for 137 residents on the quired for 135 residents on the quired for 135 residents on the quired for 134 residents on the quired				
	day shift; 17 CNAs re 09/02/2021: 14 CNAs day shift; 17 CNAs re 09/03/2021: 15 CNAs day shift; 17 CNAs re 09/04/2021: 14 CNAs day shift; 17 CNAs re	for 134 residents on the quired for 134 residents on the quired for 134 residents on the quired				
	the NHA acknowledge provide staff in accord contained in the NJD	n 11/02/2021 at 12:45 PM, ed that the facility failed to dance with the directive OH memo. She stated the scheduled nursing staff in				

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New Jersey Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 61517		(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE COM	
		B. WING			C / 02/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
ARISTAC	ARE AT MANCHESTER		BIAS AVENUE ESTER, NJ 08759			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLETE DATE
S 560	compliance with the r of nursing staff who fa staff who called out s had made many recru raised all their rates f the second quarter of acknowledged the dir stated that she believ	e 4 nemo but was not in control ailed to report to work or ick. Per the NHA, the facility utment efforts and had or nurses and aides during this year. Though the NHA ective was not met, she ed the facility was doing its vere still able to adequately	S 560			