STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. BUILDING _____ B. WING _____	08/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GALLOWAY, THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 STANDARD SURVEY: CENSUS: 86 SAMPLE: 21 + 3 closed records The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		9/1/21

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

Electronically Signed | 08/27/2021

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F 550	Continued From page 1 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility filed to ensure residents were transported from one area of the unit to another area of the unit in a dignified manner for 2 of 21 sampled residents reviewed for Dignity. Resident [redacted] and Resident [redacted] were pulled backwards in the [redacted] chair. This deficient practice was evidenced by the following: On 08/18/21 at 09:02 AM, Certified Nursing Assistant (CNA #1) was observed to be pulling backwards in a reclined [redacted] chair from the dining room and placed Resident [redacted] across from the nurses station. 1. According to the Admission Record, Resident [redacted] was admitted to the facility on [redacted],with diagnosis including but not limited to: [redacted], A review of the annual Minimum Data Set (MDS), an assessment tool used to manage care dated [redacted], revealed Resident [redacted] had [redacted]	F 550	F550 Resident rights / Exercise of rights CNA number one, and CNA number 3, were educated on the proper transport for residents in a [redacted] chairs. All residents assigned to a [redacted] chair have the potential to be affected by this practice. All CNA's were educated on the proper technique to be used while transporting residents in [redacted] chairs. The DON or designee will be responsible for monitoring and conduction monthly audits for the proper transport of all residents in a [redacted] chair. In addition, the Administrator/DON/designee is responsible for reviewing the audits for presentation at the quarterly QAPI meeting. Completion Date: 9-1-21	

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F 550	Continued From page 2 [redacted] impairment. The MDS further reflected Resident [redacted] was dependent on staff for locomotion on the unit. 2. On 8/16/21 at 12:07 PM during lunch in the [redacted] floor dining room, the surveyor observed Resident [redacted] seated in a reclined [redacted] chair. It was being pulled backwards by CNA #3 into the dining room. On 8/17/21 at 11:54 AM during lunch in the [redacted] floor dining room, the surveyor observed Resident [redacted] seated in a reclining [redacted] chair. It was being pulled backwards by an unidentified staff member. A review of a significant change MDS, dated [redacted], revealed Resident #19 was dependent on staff for locomotion on the unit. During an interview on 08/18/21 at 10:55 AM, CNA #1 who said when I transport Resident [redacted], I sit him/her upright and then pull him/her backwards so he/she doesn't fall forward. During an interview on 08/19/21 at 09:32 AM the Licensed Practical Nurse Unit Manager (LPNUM) said residents are absolutely not to be transported backwards in [redacted] chairs. During On 08/19/21 1:52 PM during an interview with the surveyor, the Director of Nursing stated, "No" when asked if staff should be pulling the recliner chair. She further stated, "It's a dignity issue." NJAC 8:39-17.4(c)	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		9/1/21

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F 584	Continued From page 3 §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced	F 584		

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F 584	Continued From page 4 by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain a clean and sanitary environment for 1 of 2 units, [redacted] floor, reviewed for environment. This deficient practice was evidenced by the following: On 8/16/21 at 10:19 AM, during the initial tour, in room [redacted] the surveyor observed dried, brown residue on the floor between the privacy curtain and the window side bed, on the wheelbase of an [redacted] On 8/17/21 at 9:40 AM, in room [redacted], the surveyor observed dried, brown residue on the floor between the privacy curtain and the window side bed. On 8/17/21 at 11:50 AM, in room [redacted], the surveyor observed dried, brown residue on the floor, near the wheelbase of an [redacted] in between the privacy curtain and window side bed. The [redacted] also had [redacted] attached. On 8/18/21 at 1:45 PM, during an interview with the surveyor, the Director of Environmental Services (DES) said every room must be mopped each day. The DES further said house keeping cleans the [redacted] and cleans the [redacted] On 8/19/21 at 9:06 AM in room [redacted], the surveyor observed dried, brown residue on the floor near the wheelbase of [redacted] in between the privacy curtain and window side bed. On 8/19/21 at 2:45 PM, during an interview with	F 584	F584 Safe/Clean/Comfortable/Homelike Environment Room [redacted] was thoroughly cleaned. All brown residue was removed. The [redacted] were removed from the room on [redacted]; [redacted] order was discontinued. Room [redacted] was thoroughly cleaned. All brown residue was removed. All residents have the potential to be affected by this practice. A facility-wide in-service was given to the Nursing and Housekeeping staff by the Infection Preventionist on providing and maintaining a safe and clean environment. Staff education stressed that everyone is responsible for the residents' environment. The [redacted] for [redacted] was discontinued and the [redacted] was removed from the room on [redacted]. All areas identified immediately and any staff who identifies an area to be cleaned is to address it. The Administrator/designee, Housekeeping Director, and Unit Managers will be responsible for monitoring the residents' living environment daily x 4 weeks and then weekly x 8 weeks. The results will be presented at the monthly QA x 3. The Administrator/DON/designee is responsible for reviewing the audits for presentation at QAPI. Completion Date: 9-1-21	

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F 584	Continued From page 5 the surveyor, the DES said that if there is a spill in a room, the nurse should clean it and notify housekeeping if necessary, but housekeeping is responsible to clean the room. A review of the August 2021 "Carbolization/Cubicle Curtain Schedule" document that was provided by the DES, revealed that on 8/4/21, room [redacted] was scheduled for "carbolization" (term used to describe a thorough cleaning) and on 8/17/21, room [redacted] was scheduled for "carbolization." A review of the "Housekeeping Assignments" document provided by the DEC revealed under, [redacted] Floor" that room [redacted] and [redacted] were included in the housekeeping assignments.	F 584		
F 690 SS=D	N.J.A.C. 8:39-31.4(f) Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 690		9/1/21

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F 690	Continued From page 6 is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to obtain a physician's order to provide [redacted] for a resident admitted to the facility with a [redacted] This deficient practice was observed for 1 of 2 residents reviewed for [redacted] (Resident [redacted]) and was evidenced by the following: On 8/16/2021 at 11:16 AM during the initial tour of the [redacted] floor unit, the surveyor observed Resident [redacted] lying in bed. On interview, the resident stated, [redacted]. On 08/17/2021 at 8:57 AM Resident [redacted] was observed lying in bed. On interview Resident [redacted] complained [redacted]. Resident [redacted] stated, [redacted]	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI Resident [redacted] had orders updated immediately to add in care for the catheter. Any resident who has a [redacted] has the potential to be affected by this practice. All nursing staff has been in-serviced by the Infection Preventionist to ensure all [redacted] have appropriate care orders. The Unit Managers will conduct daily audits x 4 weeks to ensure that orders are in place. They will follow up with weekly audits x 8. The DON/designee will review the audits and report findings at the monthly QA x 3, followed by presentation at the QAPI. Completion Date: 9-1-21	

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F 690	Continued From page 7 [redacted] "	F 690		

According to the Admission Record, Resident [redacted] was admitted with diagnoses including but not limited to [redacted], encounter for [redacted] following [redacted] on the [redacted] and [redacted] infection.

According to the Minimum Date Set (MDS), an assessment tool, resident [redacted] had [redacted] impairment. The MDS also revealed that Resident [redacted] had an [redacted].

A review of Resident [redacted] Order Summary Report dated [redacted], did not include any physician orders for care of the [redacted].

A review of the Physician's Progress Note, dated [redacted] which acknowledged in the Subjective area of the note the following: "patient seen and examine - chart reviewed - lying in bed - awake and alert - has [redacted] -"

A review of Resident [redacted] Medication Administration Record (MAR) and Treatment Administration Record (TAR) for the following dates: [redacted], and [redacted], did not include any documentation indicating care for the [redacted]

A review of the care plan revealed for that Resident [redacted] had no current care plan addressing [redacted] care.

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F 690	Continued From page 8 During an interview on 8/18/2021 at 10:15 AM, Licensed Practical Nurse (LPN #2) assigned to care for Resident [redacted] said, I'm not familiar with [redacted] but I saw [redacted] today. I'm looking, and I don't see any orders for [redacted], which is usually done on each shift. Usually, we look at it every shift and [redacted] but I don't see any orders. She went on to say that we [redacted] in the morning and evening on the 12-hour shifts. We document the output on the Treatment Administration Record (TAR). LPN #2 said I didn't do it yet today. We usually look at the [redacted] and it would be documented on the TAR. During an interview on 8/19/2021 at 1:40 PM, with the Director of Nursing (DON) Resident #22's nephrostomy tube, the DON said "We should have a policy; I would have to check into it. We should check to make sure the site is dry, monitor for signs and symptoms of [redacted]. It would require a physician's order to provide treatment or care. I've always obtained an order for [redacted] care." The DON also stated that Resident [redacted] should have had a care plan in place to address [redacted] care. The DON stated, "Yes, I would care plan a [redacted] During a follow up interview on 8/20/2021 at 9:47 AM, the DON stated I looked into this, it's going to be care planned. There should be an order for monitoring [redacted]. [redacted] care is automatic, it will go on the care plan as well. It doesn't necessarily need a physician order. I'm going to have to check our policy and determine if we need a physician's order for [redacted] care. On 8/20/202 at 11:31 AM, the DON said the	F 690		

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F 690	Continued From page 9 [redacted] should have orders and that I am going to get orders for this resident. The DON further stated that Yes, we are going to care plan the [redacted]. The resident should have had a physician's order for [redacted] care and a care plan developed upon admission. A review of an undated facility policy titled [redacted] revealed under GENERAL GUIDELINES: 1. Monitor insertion site for signs of infection every shift with routine care and report any changes or abnormalities. 2. Monitor placement of the [redacted] a. [redacted] should be below the [redacted]. b. There should be [redacted]. c. If the [redacted] dislodged, cover [redacted]) and notify the Attending Physician immediately. 3. Empty the [redacted] once per shift and as needed. 4. Change [redacted] per physician orders. 5. Measure [redacted] every shift. 6. Measure [redacted] separately. 7. If calls for dressing application, change dressings as ordered. 8. Irrigate the [redacted] as ordered. 9. Report any changes to the physician. N.J.A.C. 8:39-19.4(a)	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy	F 695		9/1/21

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F 695	Continued From page 10 care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and other facility documentation, it was determined that the facility failed to follow physician's order for [redacted] for 1 of 2 residents reviewed for respiratory care (Resident [redacted]), as well as failed to follow facility policy for changing of [redacted]. This deficient practice was evidenced by the following: On 8/17/21 at 9:38 AM, the surveyor observed Resident [redacted] was using a [redacted] to a person) . The [redacted] was connected to an [redacted] therapy). There was no [redacted] connected to the [redacted]. There was a piece of tape attached to the [redacted] that revealed a hand-written date of "8/11/21." The date indicates when the [redacted] was last changed. On 8/19/21 at 9:03 AM, the surveyor observed Resident [redacted] receiving [redacted] through the [redacted]. There was no [redacted] bottle connected to the [redacted]. During this time, while being interviewed by the surveyor, Licensed Practical Nurse (LPN #1) confirmed Resident [redacted] is supposed to have a [redacted] attached to the [redacted]. LPN #1 confirmed the physician's	F 695	F695 Respiratory/Tracheostomy Care & Suctioning Resident #37 had [redacted] changed immediately following notification of [redacted] being out of date range. Orders were changed to reflect when [redacted] was to be used. All residents who require [redacted] have the potential to be affected by this practice. The Infection Preventionist has in-serviced all licensed nurses on the practice/policy of all respiratory tubing being changed weekly and/or PRN when as per orders. The Unit Manager will complete daily audits x 4 weeks, followed by weekly x 8. The DON/designee will review the audits to present at the QA x 3, and then for presentation at QAPI. Completion Date: 9/1/21	

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F 695	Continued From page 11 order in the Medication Administration Record (MAR). On 8/19/21 at 11:00 AM, the surveyor observed Resident [redacted] seated in the hallway. His/her [redacted] was connected to a [redacted]. No [redacted] was observed. On the same date at 12:21 PM, the surveyor observed the tape attached to Resident [redacted] while he/she received [redacted] seated in the dining room. The tape revealed a hand-written date of "8/11/21." A review of Resident [redacted] medical record revealed an admitting diagnosis of but not limited to [redacted] A review of Resident [redacted] quarterly Minimum Data Set (an assessment tool); dated [redacted] revealed that he/she received [redacted] while a resident in the facility. A review of Resident [redacted] physician orders revealed an order for [redacted] delivered at [redacted]. The order had a start dated of [redacted]. A review of Resident #37's Medication Administration Record for the month of [redacted] revealed the order, [redacted] was documented as administered each shift. A review of Resident [redacted] Treatment Administration Record for the month of [redacted]	F 695		

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HEALTH CENTER AT GALLOWAY, THE	66 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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 695	Continued From page 12 [redacted] did not include documentation that the [redacted] was changed on 8/17/21. The last documented [redacted] change was 8/10/21. During an interview with the surveyor on 8/19/21 at 1:52 PM, the Director of Nursing said that [redacted] is supposed to be changed weekly. A review of the facility policy titled, [redacted] Therapy" with an effective date of 3/1/2017 and a revised date of 3/1/2021, revealed under "Procedure" 5. "A physician's order with specific conditions under which to give [redacted]."; 11. "Al[redacted] is to be changed out weekly/PRN as needed"; 12. (a) [redacted] into wall outlet and attach [redacted] (if indicated) filled with [redacted] to the front of the [redacted] N.J.A.C. § 8:39-27.1(a)	F 695		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		9/1/21

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F 812	Continued From page 13 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 8/16/2021 from 10:08 AM to 10:48 AM the surveyor, accompanied by the Director of Dietary Services (DODS), observed the following in the kitchen: 1. On an upper shelving rack of a multi-tiered rack used to store canned goods, a can of Pineapple Tidbits in Juice had a significant dent near the lower seam. On interview the DODS stated, "I must have missed that one. That should be on the dented can area." The DODS removed the can to the designated dented can area. 2. The surveyor reviewed the Healthcare Services Group Refrigerator Temperature Log, dated "Aug 2021." The log revealed that the AM temperature of the refrigerator was 36 degrees in the AM on August 17, 2021. Upon entering the walk-in refrigerator, the surveyor and DODS were unable to find an internal thermometer to check the temperature of the walk-in refrigerator. When interviewed the DODS stated, "There should be an internal thermometer. We don't have one right now. I will get one." 3. During the tour of the walk-in freezer the	F 812	F812 Food procurement, store/prepare, serve-sanitary All dented cans were removed and placed in the dented can area. A thermometer was placed in the walk-in refrigerator. The walk-in freezer the floor in the walk-in freezer was thoroughly cleaned to remove all food debris and plastic wrappers identified. The lid was placed on the plate warmer containing sanitized dishes. All residents have the potential to be affected by this practice. And in-service was given to all dietary staff to identify the proper placement of dented cans, proper placement of thermometer in the walk-in refrigerator, cleanliness in the walk-in freezer and food service department, and the need to make sure the plate warmer is covered at all times. The food service director or designee will be responsible for monitoring the proper placement of dented cans, proper placement of thermometer in the walk-in refrigerator, cleanliness and sanitary in the walk-in freezer and food service department, and that the plate warmer is covered at all times. The FSD will audit daily x 4 weeks and then weekly x 8 weeks. The results will be presented at the monthly QA x 3. The Administrator/FSD/designee is	

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F 812	Continued From page 14 surveyor observed several patches of ice buildup on the floor as well as, unidentifiable food debris and plastic wrappers throughout the freezer floor. On interview the DODS stated, "Yeah, it could use a cleaning. The floor gets cleaned twice a week on Tuesdays and Fridays. We also clean as needed." 4. A plate warmer contained cleaned and sanitized plates used for resident meals and was observed in the dish washing room while active dishwashing from the breakfast meal was being conducted. The plate warmer did not have a lid to cover the plates and the plates were not inverted and were exposed to contamination. On interview the DODS stated, "They should be covered and not exposed." A review of a facility policy titled "Food Storage: Cold Foods", HCSG Policy 019, with revised date of 9/2017, revealed the following under the heading Procedures: 4. "An accurate thermometer will be kept in each refrigerator and freezer. A written record of daily temperatures will be recorded." A review of an undated facility policy/in-service titled Healthcare Services Group Receiving and Storage of Food revealed under Guidelines for Receiving Foods: "Reject unacceptable goods and note this rejection on the invoice. Examples of unacceptable products are: Dented or bulging cans." The policy/Inservice further revealed the following under the heading Frozen Storage: "Keep the shelving and floor clean. Clean up spills as they occur." N.J.A.C. 8:39-17.2(g)	F 812	responsible for reviewing the audits for presentation at QAPI. Completion Date: 9-1-21	

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	060102	A. BUILDING: _____ B. WING _____	08/20/2021

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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: Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the state of New Jersey. This was evident for 17 of 35 day shifts reviewed. 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	All residents are potentially affected by this practice Rates were increased, and Ads updated to reflect increases allowing us to hire staff to meet the required ratio. In addition, the facility will use agency staff when there is a need to meet the required staffing ratio. The DON to have weekly meetings to determine upcoming schedules to anticipate needs The DON or designee will conduct monthly audits of the staffing patterns and	9/1/21

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

Electronically Signed | 08/27/21

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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. As per the "Nursing Staffing Report" completed by the facility for the weeks of 7/4/21-7/10/21, 7/11/21-7/17/21, 7/18/21-7/24/21, 8/1/21-8/7/21 and 8/8/21-8/14/21, the staffing to residents ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below: 7/4 - 11 CNAs for 98 residents 7/10 - 11 CNAs for 96 residents 7/11 - 11 CNAs for 96 residents 7/12 - 11 CNAs for 96 residents 7/13 - 9 CNAs for 96 residents 7/17 - 8 CNAs for 96 residents 7/18 - 10 CNAs for 94 residents 7/22 - 10 CNAs for 90 residents 7/24 - 9 CNAs for 88 residents. 8/5 - 11 CNAs for 91 residents 8/6 - 11 CNAs for 91 residents	S 560	ratios and report findings to the Administrator. In addition, the DON/designee will notify the results to the QA committee monthly for action as appropriate. Completion date; 9-1-21	

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S 560	Continued From page 2 8/7 - 11 CNAs for 91 residents 8/8 - 11 CNAs for 91 residents 8/9 - 11 CNAs for 91 residents 8/10 - 8 CNAs for 91 residents 8/11 - 8 CNAs for 90 residents 8/14 - 7 CNAs for 88 residents During an interview on 8/18/21 at 12:26 PM, the Human Resources/Staffing Coordinator (HR/SC) said I have and am using temporary nurse assistants. She went on to say that I am aware of the staffing requirements for CNA staffing. She also said I am responsible to make sure we meet the required hours. The HR/SC said no I have not scheduled a nurse to take a CNA assignment. The HR/SC said most of the days, we meet the requirements on all three shifts. During an interview on 8/19/21 at 1:52 PM, he Director of Nursing (DON) and Administrator said they are aware of the minimum staffing ratios. The DON said yes we are meeting the staffing ratios and use temporary nurse aides and agency staffing. A review of an undated facility policy under Staffing Policy Statement revealed Our facility provides adequate staffing to meet needed care and services for our resident population. Under the policy section indicated Direct care staff to resident ratio 1. one certified nurse aide to every eight (8) residents for the day shift.	S 560		