New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	060302		B. WING		C 06/02/2021		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
ASPEN HILLS HEALTHCARE CENTER 600 PEMBERTON BROWN MILLS RD PEMBERTON, NJ 08068							
(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 560	8:39-5.1(a) Mandatory Access to Care		S 560			7/12/21	
	Federal, State, and regulations.	comply with applicable local laws, rules, and					
	by:	NT is not met as evidenced					
	Complaint Intakes: Based on interviews the facility failed to emet for 20 of 26 shi no increase in the runine consecutive sh had the potential to census was 163 at Findings include: Reference: New Jet (NJDOH) memo, dawith N.J.S.A. (New 30:13-18, new mininursing homes," inc Governor signed int codified at N.J.S.A. established minimu	NJ139832, NJ139275 s and facility document review, ensure staffing ratios were fts reviewed. There had been esident census for a period of offs. This deficient practice affect all residents. The the time of the survey. Treey Department of Health ated 01/28/2021, "Compliance Jersey Statutes Annotated) mum staffing requirements for dicated the New Jersey to law P.L. 2020 c 112, 30:13-18 (the Act), which m staffing requirements in efollowing ratio(s) were 2021:		I. Corrective action(s)accomplish resident(s)affected: "Resident #5 was immediately incontinent care. II. Residents identified having the potential to be affected and correct action taken: "The deficient practice has the potential to affect all residents resist the facility. III. Measures will be put into place ensure the deficient practice will not make the deficient practi	provided etive ding in eto ot recur: rsing en euses shifts, on. are		
	for the day shift.	aid to every eight residents		The call out Policy has been reand the staff has been re-educatedAdvertisements signs are plact bus stops in front of the building.	d ed by		
	residents for the ever fewer than half of all certified nurse aides member shall be sig	ff member to every 10 ening shift, provided that no ll staff members shall be s, and each direct staff gned in to work as a certified ll perform nurse aide duties;		Advertisements for available C positions have been placed in the newspaper. The facility is recruiting on mulemployment search engines and newspaper and newspaper. Depending on the needs of the control o	local Itiple nultiple		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/23/21

New Jersey Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		060302	B. WING		06/0	; 2/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
600 PEMBERTON BROWN MILLS RD							
ASPEN	HILLS HEALTHCARE	PEMBER1	TON, NJ 080	068			
(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 560	Continued From page 1		S 560				
	REGULATORY OR LSC IDENTIFYING INFORMATION)						
	Coordinator (SC) or The SC acknowledge	ompleted with the Staffing n 06/01/2021 at 12:50 PM. ged the state required staffing o staff to those numbers."					

PRINTED: 07/08/2021 FORM APPROVED

New Jersey Department of Health

STATEMENT OF DEFICIENCIES (X1) P

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	(X3) DATE SURVEY COMPLETED	
7 1.5 1 27 1	0. 00.m.20.m.	.52	A. BUILDING:				
		060302	B. WING			C)2/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
ASPEN HILLS HEALTHCARE CENTER 600 PEMBERTON BROWN MILLS RD PEMBERTON, NJ 08068							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	