

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/02/2022
NAME OF PROVIDER OR SUPPLIER ASPEN HILLS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>COMPLAINT #: NJ 154548</p> <p>CENSUS: 180</p> <p>SAMPLE SIZE: 4</p> <p>THE FACILITY IS IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR, PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

09/02/2022

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.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060302	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/02/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ASPEN HILLS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	<p>Initial Comments</p> <p>COMPLAINT #: NJ 154548</p> <p>CENSUS: 180</p> <p>SAMPLE SIZE: 4</p> <p>The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:39, Standards for Licensure of Long-Term Care Facilities.</p> <p>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 provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.</p>	S 000		
S 560	<p>8:39-5.1(a) Mandatory Access to Care</p> <p>(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.</p> <p>This REQUIREMENT is not met as evidenced by: C#: #154548</p> <p>CENSUS: 180</p> <p>SAMPLE SIZE: 4</p> <p>Based on facility document review on 8/2/2022, it was determined that the facility failed to ensure staffing ratios were met to maintain the required</p>	S 560	<p>Corrective action(s) accomplished for resident(s) affected:</p> <p>" No residents were identified</p> <p>II. Residents identified having the potential to be affected and corrective action taken:</p> <p>" The deficient practice has the potential to affect all residents residing in the facility.</p>	9/12/22

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

TITLE

(X6) DATE

Electronically Signed

09/02/22

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060302	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/02/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ASPEN HILLS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 1</p> <p>minimum staff-to-resident ratios as mandated by the State of New Jersey for 6 of 7 Certified Nurse's Aides (CNAs) for Day shifts. This deficient practice had the potential to affect all residents. Findings include:</p> <p>Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with NJSA (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law PL 2020 c 112, codified as NJSA 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021:</p> <p>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.</p> <p>The facility was deficient in Staffing as follows:</p> <p>6 of 7 CNA day shift staffing as follows:</p> <p>On 4/24/22 The facility had 13 CNAs for 169 residents for day shift, required 21 On 4/25/22 The facility had 16 CNAs for 169 residents for day shift, required 21 On 4/26/22 The facility had 19 CNAs for 169 residents for day shift, required 21 On 4/28/22 The facility had 19.5 CNAs for 169</p>	S 560	<p>III. Measures will be put into place to ensure the deficient practice will not recur:</p> <p>" The facility currently has 6 Nursing Agency contracts. " The daily bonus range has been reviewed and increased. Daily bonuses are offered for double shifts, extra shifts, weekend shifts and staff recognition. " Referral and sign on bonuses are offered. " The call out Policy has been reviewed and the staff has been re-educated " Advertisements signs are placed by bus stops in front of the building. 1. Advertisements for available C.N.A. positions have been placed in the local newspaper. " The facility is recruiting on multiple employment search engines and multiple social media platforms. " Depending on the needs of the day Nursing management to include Unit Mangers, Supervisors and ADON will be evaluated to assist with resident care. " Rates have been increased for C.N.As</p> <p>IV. Corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>" The DON/Designee will conduct weekly C.N.A. staffing schedule audits. " The DON/Designee will report audit findings to the Administrator. The Administrator/Designee will analyze and trend findings and report outcomes quarterly to the QA Committee for the next meeting, with follow up to recommendations, as necessary.</p>	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060302	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/02/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ASPEN HILLS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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	Continued From page 2 residents for day shift, required 21 On 4/29/22 The facility had 20 CNAs for 167 residents for day shift, required 21 On 4/30/22 The facility had 20 CNAs for 166 residents for day shift, required 21	S 560		