

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

PRINTED: 06/10/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/17/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>STERLING MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>794 N FORKLANDING ROAD</b> <b>MAPLE SHADE, NJ 08052</b>		
(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 #: NJ171950, NJ172348, NJ172531, NJ172852</p> <p>Census: 91</p> <p>Sample Size: 6</p> <p>THE FACILITY IS IN SUBSTANTIAL 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

05/03/2024

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:  <b>060312</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>04/17/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>STERLING MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052</b>
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S 000	Initial Comments  The facility was not in compliance with the standards in the New Jersey Administrative code, 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: Complaint #: NJ171950, NJ172348, NJ172531, NJ172852  Based on interviews and review of facility documents on 4/16/2024 and 4/17/2024, it was determined that the facility failed to ensure staffing ratios were met for 9 of 14-day shifts reviewed. 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 nursing homes," indicated the New Jersey	S 560	Immediate Action A new staffing coordinator replaced the former coordinator on [redacted] NJ Exec. Order 26. New coordinator was educated on New Jersey state staffing ratio requirements on [redacted] NJ Exec. Order 26.  Identification of Others All residents have the potential to be affected by the deficient practice.  Systemic changes 1. New experienced staffing coordinator replaced our prior coordinator on [redacted] NJ Exec. Order 26. Prior coordinator is available to the new coordinator for additional assistance.	5/6/24

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S 560	<p>Continued From page 1</p> <p>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:</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 CNA staffing for residents on 9 of 14 day shifts as follows:</p> <p>On 03/31/24 had 8 CNAs for 80 residents on the day shift, required at least 10 CNAs.                      On 04/03/24 had 9 CNAs for 80 residents on the day shift, required at least 10 CNAs.                      On 04/07/24 had 7 CNAs for 86 residents on the day shift, required at least 1 CNAs.                      On 04/08/24 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs.                      On 04/09/24 had 10 CNAs for 86 residents on the day shift, required at least 1 CNAs.                      On 04/10/24 had 7 CNAs for 86 residents on the day shift, required at least 11 CNAs.                      On 04/11/24 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs.                      On 04/12/24 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs.                      On 04/13/24 had 9 CNAs for 87 residents on the day shift, required at least 11 CNAs.</p>	S 560	<p>2. Efforts to hire facility staff will continue until there is adequate staff to meet the minimum staff to resident ratios. The facility will use staffing agencies and offer additional shifts to current staff with bonuses as required.</p> <p>3. Facility Administrator worked with Human resources to secure additional staffing agency contracts.</p> <p>4. Successful job fair held on 3.27.24 resulting in LPN and CNA new hires.</p> <p>5. Weekly recruitment, retention and employee appreciation meeting has been initiated and is led by the Director of Human Resources and/or designee.</p> <p>6. Hiring and recruitment efforts including pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to continue to be competitive in the marketplace.</p> <p>7. Focus on retention efforts include, but are not limited to incentive programs, career growth and educational training opportunities and employee morale incentives.</p> <p>8. The facility administrator/designee will continue to track and document all recruitment and retention efforts weekly.</p> <p>9. The administrator/designee will review staffing schedules weekly to ensure adequate staffing for all shifts.</p> <p>Quality monitoring The results of these reviews will be</p>	

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S 560	Continued From page 2	S 560	submitted to the Quality Assurance Performance Improvement Committee monthly for 6 months. Based on the audit results, a decision will be made regarding the need for continued submission and reporting.	

**STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 060312	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 5/10/2024
NAME OF FACILITY STERLING MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052	

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	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	05/06/2024	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 4/17/2024	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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