STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315174	A. BUILDING _____ B. WING _____	C 06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	**1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096**

(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 A Complaint Survey was conducted on behalf of the New Jersey Department of Health. Complaint #s: NJ00159266, NJ00159274, NJ159849, NJ00160010, NJ00160406, NJ00162765, NJ00163909, NJ00164203, and NJ00164267. Survey Dates: 06/11/23 through 06/14/23 Survey Census: 198 Sample Size: 11 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following	F 725		7/25/23

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

Electronically Signed | 07/19/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315174	A. BUILDING _____ B. WING _____	C 06/14/2023

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DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	**1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096**

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F 725	Continued From page 1 types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Complaint #'s : NJ00159849, NJ00163909 Based on observations and interviews, the facility failed to ensure sufficient staffing to meet the needs of 138 residents in the facility. One resident (Resident (R) 2) and staff members (Licensed Practical Nurse 1, LPN2, and LPN3), Certified Nurse Aides (CNA2 and CNA3), and Housekeeper 1 voiced concerns regarding sufficient staffing. Findings include: Review of R2's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed R2 was admitted to the facility on [redacted] with diagnoses including [redacted] Review of R2's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 05/11/23, revealed R2 scored a [redacted] out of 15 on the "Brief Interview for Mental Status," which indicated R2 was [redacted]	F 725	Element 1: The facility schedules were reviewed and staffing was added to meet the minimum requirement of direct care staff to resident ratio, as well as staffing for indirect care. Resident 2 had medication and Activities of Daily Living charts review, and was found that resident received medications as well as Activities of Daily Living care in a timely manner on all shifts; call bell audits were conducted for Resident 2, and any deficient practices were corrected immediately. Staffing was reviewed for overnights and weekends, and was found to be adequate per regulations. In addition, A complete [redacted] check was done for resident 2, and he did not have any noted [redacted] Resident 2 record was evaluated, and the resident was found to be with no signs or symptoms of [redacted]. Resident number 2 did not suffer any negative outcome from reported deficient practice.	

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F 725	Continued From page 2 During an interview on 06/11/23 at 10:48 am, R2 stated [redacted] experienced long wait times for care to be delivered. R2 stated [redacted] had to wait lengthy periods of time for assistance with [redacted] and [redacted]. R2 stated this usually occurred on the weekends and at night. On 06/13/23 at 9:30 AM, staffing schedules were reviewed with the Director of Nursing (DON). The DON stated she was aware that additional staff were needed. She stated the facility was always recruiting and hiring support staff such as CNAs and housekeeping staff, but the geographical area had many long term care/healthcare facilities that were competing for a limited number of CNAs in the area, so the turn-over rate was very high. The DON stated that the facility did use agency staff as a last resort, but they preferred to provide incentives for their own employees for quality, consistent care. Random CNAs and Licensed Practical Nurses and Registered Nurses were asked about their staffing and workloads. CNAs 1 and 2 stated there were days when there were not enough CNAs to get everything done. CNA 1 stated she missed the time when they could socially interact with the residents, but now verbal interaction only occurred during toileting or dressing. In an interview on 06/14/23 at 2:30 PM with the Nurse Practitioner, the DON, the Administrator, and the Regional Nurse, the staff members stated that the population in the facility was younger to middle aged residents who had [redacted] All concurred that the	F 725	Element 2: All residents have potential to be affected by this deficient practice. The facility schedules were reviewed and additional staff was added to meet the requirements for direct and indirect care staff to resident ratio. Element 3: The staffing coordinator was educated on ensuring that adequate staffing levels are reached to comply with all state and Federal requirements for direct/indirect care staff to resident ratio. The staffing coordinator will present the daily schedule to the DON and Administrator to ensure adequate staffing is achieved every day for all shifts. Continued hiring for all nursing and non-nursing positions. Element 4: The administrator will audit schedules to ensure direct care staff to resident ratio requirement is met. Audits will be completed weekly x 4 weeks and monthly until compliance is met. The results of these audits will be presented at monthly QAPI. The DON and Administrator are responsible for execution and monitoring	

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F 725	Continued From page 3 resident acuity required additional staff for increased supervision and to reduce opportunities for behavioral concerns in the facility. Multiple staff interviews were conducted with CNAs2 and 3, as well as with LPNs 1, 2, and 3. The staff worked both shifts and all halls. The staff interviews revealed that the staff felt their assignments were usually manageable, but if one person did not show up for work, then staffing for the entire shift was ruined. During an interview on 06/11/23 at 2:10 PM, Housekeeper 1 stated that if one person did not show up for work, she had to clean the whole building. Housekeeper 1 stated that could not be done. Housekeeper 1 stated that did not happen very often, but it did happen. The DON and Administrator were interviewed on 06/14/23 at 10:15 AM. The DON stated they did supplement their staff with agency nurses and CNAs when they had to, but they preferred to offer incentives to their own employees. Both stated their staffing had improved and they were still hiring for all positions.,. A facility policy was requested related to adequate staffing, and the DON stated she did not think they had a policy that addressed that specifically, but her expectation was always to have enough staff to meet the residents needs on all shifts, including the weekends. NJAC :8:39-5.1 (a)	F 725	of this POC.	

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	060804	A. BUILDING: _____ B. WING _____	C 06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AI	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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S 000	Initial Comments Complaint #s: NJ00159266, NJ00159274, NJ159849, NJ00160010, NJ00160406, NJ00162765, NJ00163909, NJ00164203, and NJ00164267. Survey Dates: 06/11/23 through 06/14/23 Survey Census: 198 Sample Size: 11 The facility is 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: Complaint #'s : NJ159849, NJ00163909 Based on review of pertinent facility documentation, it was determined that the facility	S 560	Element 1: The facility schedules were reviewed and staffing was added to meet the minimum requirement of direct care staff to resident ratio.	7/19/23

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

Electronically Signed | 07/19/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 13 of 14 day shifts, 2 of 14 evening shifts and 3 of 14 overnight shifts as follows: 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 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: 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. As per the "Nurse Staffing Report" completed by the facility for the 2 weeks of staffing from 05/28/2023 to 06/10/2023, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift and one direct care staff member to every 10 residents for the evening shift as documented	S 560	Element2: All residents have potential to be affected by this deficient practice. The facility schedules were reviewed and additional staff was added to meet the requirements for direct care staff to resident ratio. The facility will strive to meet the New Jersey minimum staffing requirement for certified nurse aids of: Day shift- 1:8; Evening shift – 1:10; Night Shift – 1:14 Element 3: The staffing coordinator was educated on ensuring that adequate staffing levels are reached to comply with the NJ state requirement for direct care staff to resident ratio. The staffing coordinator will present the daily schedule to the DON and Administrator to ensure adequate staffing is achieved every day for all shifts. Continued hiring for all nursing positions both nurses and cna's. Element 4: The administrator will audit schedules to ensure direct care staff to resident ratio requirement is met. Audits will be	

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S 560	Continued From page 2 below: The facility was deficient in CNA staffing for residents on 13 of 14 day shifts, deficient in total staff for residents on 2 of 14 evening shifts and deficient in total staff for 3 of 14 overnight shifts as follows: -05/28/23 had 16 CNAs for 205 residents on the day shift, required 26 CNAs. -05/28/23 had 18 total staff for 205 residents on the evening shift, required 20 total staff. -05/29/23 had 19 CNAs for 204 residents on the day shift, required 20 CNAs. -05/29/23 had 19 total staff for 204 residents on the evening shift, required 20 total staff. -05/30/23 had 17 CNAs for 204 residents on the day shift, required 25 CNAs. -05/30/23 had 14 total staff for 204 residents on the overnight shift, required 15 total staff. -05/31/23 had 23 CNAs for 202 residents on the day shift, required 25 CNAs. -06/01/23 had 21 CNAs for 202 residents on the day shift, required 25 CNAs. -06/02/23 had 20 CNAs for 200 residents on the day shift, required 25 CNAs. -06/03/23 had 21 CNAs for 197 residents on the day shift, required 25 CNAs. -06/03/23 had 13 total staff for 197 residents on the overnight shift, required 14 total staff. -06/04/23 had 19 CNAs for 195 residents on the day shift, required 24 CNAs. -06/05/23 had 20 CNAs for 195 residents on the day shift, required 24 CNAs. -06/05/23 had 12 total staff for 195 residents on the overnight shift, required 14 total staff. -06/06/23 had 23 CNAs for 195 residents on the	S 560	completed weekly x 4 weeks and monthly until compliance is met. The results of these audits will be presented at monthly QAPI. The Administrator is responsible for execution and monitoring of this POC.	

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S 560	Continued From page 3 day shift, required 24 CNAs. -06/08/23 had 20 CNAs for 198 residents on the day shift, required 25 CNAs. -06/09/23 had 21 CNAs for 196 residents on the day shift, required 24 CNAs. -06/10/23 had 18 CNAs for 196 residents on the day shift, required 24 CNAs.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315174		7/25/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 F0725 Reg. # 483.35(a)(1)(2) LSC	Correction Completed 07/25/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
6/14/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060804 Y1	A. Building B. Wing Y2	7/25/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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 Reg. # 8:39-5.1(a) LSC	Correction Completed 07/19/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 6/14/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO