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

PRINTED: 02/10/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315177	B. WING _			C 01/13/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS 139 GRANT AVE EATONTOWN,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EAC	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD S-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENTS	3	F	00		
	COMPLAINT# NJ	130223				
	CENSUS: 159					
	SAMPLE SIZE : 3					
L ABORATORY	I DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATU	IRF		TITLE	(X6) DATE

Electronically Signed 01/31/2020

Facility ID: NJ61305

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

NAME OF PROVIDER OR SUPPLIER  GATEWAY CARE CENTER  139 GRANT AVE EATONTOWN, NJ 07724  (X4) ID PREFIX TAGE (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S1680 8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing  (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a) above) on the basis of:  1. Total number of residents multiplied by 2.5 hours/day; plus  2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day:	STATEMENT OF DEFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  139 GRANT AVE EATONTOWN, NJ 07724  (IXA) ID. PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  (IXA) ID. PREFIX TAG  (IXA) ID. PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  S1680  8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing  (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing in facilities where the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a) above) on the basis of:  1. Total number of residents multiplied by 2.5 hours/day; plus  2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day:	AND I LAN OF CORRE	SOUTECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COMITETED			
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CATEWAY CARE CENTER			061305	B. WING		01/13/2020	<u>'</u>		
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O.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day	(b) The register nurses of nurses of nurses of nursexcept nursing provide at N.J./  1. hours/o  2. service co  W. 0.7  gastros  1.2	o) The facility shall pegistered profession urses, and nurse aid financial f	provide nursing services by hal nurses, licensed practical des (the hours of the director cluded in this computation, care hours of the director of there the director of nursing the minimum hours required 1(a) above) on the basis of:  of residents multiplied by 2.5  of residents receiving each multiplied by the number of hours per day:  c tube feedings and/or  1.00 hour/day  erapy  my  s therapy day in a stimulation/advanced						

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

(X6) DATE TITLE

**Electronically Signed** 

If continuation sheet 1 of 3

01/31/20

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		061305	B. WING		O1/1:	C <b>01/13/2020</b>	
	ROVIDER OR SUPPLIER	STREET ADD	PRESS, CITY, STA T AVE WN, NJ 07724		, , , , , ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
S1680	by: COMPLAINT # 13022  Based on review of the week of 10/27/20 the facility staff failed staffing levels for 1 of staffing hours are as a serior of the week of 10/27 hours: 410.00  Date Actual 10/27/2019 400  During a post survey 1/23/2020 at 3:25 p.m (DON) stated that who "try to cover, also call Nursing Assistants) to Activities depending of	is not met as evidenced  23  The Nurse Staffing Reports for 19, it was determined that to provide at least minimum 17 days. The required follows:  27/2019 required staffing  Staffing Hours. Difference -10.00  It lephone interview on 1. the Director of Nursing en they have call outs they nurses, CNAs (Certified to cover, also include on what they need. We call tant Director of Nursing),	S1680	Element 1 – Corrective Actions The facility has placed additional ads online staffing sites. Staffing for the d 10/27/19 was re-evaluated taking into consideration all nursing staff on that to ensure the numbers were properly calculated.  The staffing coordinator was counsele about notifying the nursing supervisor and/or the ADON and DON in the eve nurse staffing does not meet minimum requirements.  Element 2 – Identification of Resident Risk All residents may be affected by this practice.  Element 3 – Systemic Change Nursing management met to review the current staffing model to ensure it meaning to the current staffing requirements. The management team met with ownershid discuss additional incentives to attract more nursing staff during the existing staffing crisis.	lay of date ed ent n		

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		061305	B. WING		C 01/13/2020
					1 01/10/2020
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, ST	ATE, ZIP CODE	
GATEWAY	CARE CENTER		ANT AVE FOWN, NJ 07724	1	
()(1) ID	STIMMARY ST	FATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
S1680	Continued From pag	e 2	S1680	Nursing supervisors were re-educate about calculating nurse staffing requirements and the procedure to not the ADON/DON/designee at the beging of a shift if the minimum requirement	otify nning is
				not met so additional staff can be call including nursing management.  The current monthly nurse staffing schedule and daily staffing schedule were reviewed and revised to clarify required staffing and is reviewed by nursing management daily to ensure adequate staff are onsite every day at three shifts. Nursing staff received re-education regarding changes.	forms
				Element 4 – Quality Assurance Daily the DON/ADON/Nursing Super reviews the daily nurse staffing sheet ensure staffing levels comply with red staffing levels. Weekly the nurse staff schedules are reviewed by the DON/ADON to ensure adequate staff scheduled to meet staffing regulation Findings from these reviews are anal in aggregate every monthly the DON reports the findings at the quarterly C meeting for action as appropriate.	s to quired fing are s. yzed who