STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315309	A. BUILDING _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT WHITING	23 SCHOOLHOUSE ROAD WHITING, NJ 08759

(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 Complaint #: NJ#156370, NJ#156705 Census: 139 Sample Size: 5 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 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Complaint # NJ#156705 Based on interview and review of facility documents on 11/30/23, it was determined that the facility failed to ensure a Registered Nurse (RN) worked for at least eight consecutive hours	F 727	The Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of	12/28/23

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

Electronically Signed | 01/02/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 727	Continued From page 1 a day for 8 of 28 days reviewed. This deficient practice was evidenced by the following: Review of the "Nurse Staffing Reports" completed by the facility for the weeks of 07/17/22 through 07/23/22, 07/31/22 through 08/06/22, 11/12/23 through 11/18/23 and 11/19/23 through 11/25/23, revealed that the facility had no RN coverage for all shifts on 07/17/22, 07/31/22, 08/02/22, 08/03/22, 08/06/22, 11/18/23, 11/19/23 and 11/24/23. During a telephone interview with the surveyor on 12/01/23 at 11:00 am, the surveyor inquired about RN staffing in the building. The Licensed Nursing Home Administrator (LNHA) stated, "Yes, there should be at least one RN in the building." During a follow-up telephone interview with the surveyor on 12/01/23 at 2:17 pm, the LNHA confirmed that there was no RNs in the building on the aforementioned dates. The LNHA further stated, "No RNs were available to come into the building. There should have been RNs in the building." Review of the facility policy, "Staffing", under the "Policy Statement" section revealed, "This facility provides adequate staffing to meet needed care and services for our resident population." Under the "Policy and Interpretation and Implementation" section revealed "1. This facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services." NJAC 8:39-25.2(h)	F 727	deficiencies. The plan of correction was prepared and/or executed solely because it is required by the provisions of federal and state laws F 727 I. Element 1 Corrective Action a. The RN coverage in question was reviewed and areas were identified that were not covered. The facility cannot retroactively change the deficient practice II. Element 2 Identification of Others a. An assessment of the risk this could present to the residents was completed and all residents could have been affected by this practice. No residents were affected by this deficient practice. III. Element 3 Systemic Changes a. The administrator, director of nursing, human resources manager and staffing coordinator initiated the following employee recruitment efforts: 1. Use of new agencies 2. Use of recruiters 3. Offer staff bonuses 4. Offer agency staff bonuses 5. Increase bonuses when necessary 6. Offer job fairs on a monthly basis 7. Referral bonuses for current employees offered 8. Sign on bonuses for RNs b. All staffing schedules will be reviewed by the DON/ADON/Designee. The schedules will be analyzed for the proper amount of RN coverage for each 24 hour period. IV. Element 4	

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ARISTACARE AT WHITING	23 SCHOOLHOUSE ROAD WHITING, NJ 08759

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F 727	Continued From page 2	F 727	Quality Assurance a. The schedule will be reviewed daily by the DON/Designee for RN coverage for one month. b. Education provided to the Staffing Coordinator c. A random audit will be conducted weekly for compliance for 3 months. d. All findings will be presented at the QAPI meetings monthly for further discussions and/or actions for three months	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842		12/28/23

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F 842	Continued From page 3	F 842		

records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and

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F 842	Continued From page 4 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint #: NJ#156370 Based on interviews, medical record review, and review of other pertinent facility documents on 11/30/23, it was determined that the facility staff failed to consistently document on the "Point of Care (POC) Legend Report" the Activities of Daily Living (ADL) status and care provided to a resident. The deficient practice was identified for Resident #4, 1 of 5 residents reviewed for documentation and was evidenced by the following: The surveyor reviewed the closed record for Resident #4: According to the Admission Record, Resident #4 was admitted on [redacted], with medical diagnoses that included but were not limited to: [redacted] Review of the discharge Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], indicated Resident #4's [redacted] The MDS also indicated the resident required [redacted] Review of Resident #4's "POC Legend Report" form, (a form that documents the ADL care provided by the Certified Nursing Assistants (CNAs)) for 07/01/22 through 07/14/22, revealed blank spaces indicating the tasks were not completed as follows:	F 842	The Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared and/or executed solely because it is required by the provisions of federal and state laws F 842 I. Element 1 Corrective Action a. Upon review of the POC this deficient practice was identified at the facility for 1 of 5 medical records reviewed. The documentation cannot be corrected retroactively. II. Element 2 Identification of Others a. All residents have the potential to be impacted by this practice. b. No residents were noted to have been impacted. III. Element 3 Systemic Changes a. Point of Care (C.N.A. documentation) reports will be reviewed in the 24 hour morning meeting by the nursing management team/designee. b. Any incomplete areas will be analyzed to determine who did not complete the documentation and will be required to	

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F 842	Continued From page 5 Eating: 07/06/22, 07/07/22, 07/09/22, and 07/10/22 Toilet use: 07/06/22, 07/09/22, and 07/10/23 Transfer: 07/06/22, 07/09/22, and 07/10/22 Personal Hygiene: 07/06/22, 07/09/22, and 07/10/22 Bed Mobility: 07/06/22, 07/09/22, and 07/10/22 Dressing: 07/06/22, 07/07/22, 07/09/22 and 7/10/22. During an interview with the surveyor on 11/30/23 at 12:11 PM, the CNA stated that it is important to document ADL care because it indicated that the tasks were completed. The CNA further stated the importance of accurate documentation was so the facility could track the resident's condition and determine if other treatment was required. During an interview with the surveyor on 11/30/23 at 12:15 PM, the Licensed Practical Nurse (LPN) stated the CNAs were responsible for performing ADL care and documenting every shift. The LPN stated it was important to document ADL care because if it was not documented, then it looks like it was not getting done. The LPN further stated, "If it's not documented, it's not done." During an interview with the surveyor on 11/30/23 at 3:04 PM, and in the presence of the LNHA, the Director of Nursing (DON) stated that the CNAs were responsible to complete ADL care, and they should document when care is provided to the resident. The DON further stated that blanks on the ADL sheet meant care wasn't documented as provided to the resident. The DON reviewed Resident #4's ADL sheets, in the presence of the surveyor, for 07/01/22 through 07/11/22 and confirmed there were blank spaces on 07/06/22,	F 842	complete their documentation within 48 hours. IV. Element 4 Quality Assurance a. DON/ADON/Designee will conduct daily audits of Point of Care (C.N.A. documentation) for four weeks and then random audits for three months. b. Education provided to nurses and C.N.A.s c. All findings will be presented at the monthly QAPI meetings for further discussion and/or actions.	

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F 842	Continued From page 6 07/07/22, 07/09/22 and 07/10/22. The DON stated, "If the task was completed, it should be filled out. If it is not documented, the CNAs can't prove it was done." During the same interview with the surveyor, the LNHA, stated, "It is important to document ADL care to prove it was done and hold people accountable." Review of the facility undated "Activities of Daily Living" policy, revealed under the "Purpose" section that, "2. Resident's ADLs include: bathing, showering, and dressing, getting in and out of bed safely, walking, using the toilet and eating." Under the "Documentation" section revealed, that "the above information should be documented in POC/PCC." NJAC 8:39-35.2 (d)(6).	F 842		

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S 000	Initial Comments Complaint#: NJ#156705 CENSUS: 139 SAMPLE SIZE: 5 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 deficieny 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 # NJ#156705 Based on interview and review of pertinent facility documentation on 11/30/23, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 27 out of 28 day shifts, 2 out of 28 evening shifts and 6 out of 28 overnight shifts reviewed.	S 560	The Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared and/or executed solely because it is required by the provisions of federal and state laws	12/27/23

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

Electronically Signed | 01/02/24

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S 560	Continued From page 1 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 at 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 than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA 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. The surveyor requested staffing for the weeks of 07/17/22 to 07/23/22, 07/31/22 to 08/06/22, 11/12/23 to 11/18/23, and 11/19/23 to 11/25/23. As per the "Nurse Staffing Report," completed by the facility for the weeks of 07/17/22 to 07/23/22, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 4 of 7 overnight shifts as follows: -07/17/22 had 9 CNAs for 149 residents on the	S 560	S560 Element 1 Corrective Action a. The staffing schedules in question were reviewed and shifts were identified that were not covered. The facility cannot retroactively change the deficient practice. Element 2 Identification of Others a. An assessment of the risk this could present to the residents was completed and all residents could have been affected by this practice. There were no residents affected by this deficient practice. Element 3 Systemic Changes c. The administrator, director of nursing, human resources manager and staffing coordinator initiated the following employee recruitment efforts: 1. Use of new agencies 2. Use of recruiters 3. Offer staff bonuses 4. Offer agency staff bonuses 5. Job fairs on a monthly basis 6. New round of C.N.A. course offered 7. Referral bonuses for current employees offered 8. Sign on bonuses 9. Continued use of temporary nursing assistants 10. Renew contracts of travel C.N.A.s d. Findings will be reported to the administrator Element 4 Quality Assurance	

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S 560	Continued From page 2 day shift, required at least 19 CNAs. -07/17/22 had 10 total staff for 148 residents on the overnight shift, required at least 11 total staff. -07/18/22 had 9 CNAs for 148 residents on the day shift, required at least 18 CNAs. -07/19/22 had 13 CNAs for 148 residents on the day shift, required at least 18 CNAs. -07/19/22 had 8 total staff for 148 residents on the overnight shift, required at least 11 total staff. -07/20/22 had 14 CNAs for 148 residents on the day shift, required at least 18 CNAs. -07/21/22 had 15 CNAs for 147 residents on the day shift, required at least 18 CNAs. -07/21/22 had 9 total staff for 147 residents on the overnight shift, required at least 10 total staff. -07/22/22 had 14 CNAs for 145 residents on the day shift, required at least 18 CNAs. -07/23/22 had 11 CNAs for 145 residents on the day shift, required at least 18 CNAs. -07/23/22 had 8 total staff for 145 residents on the overnight shift, required at least 10 total staff. As per the "Nurse Staffing Report," completed by the facility for the weeks of 07/31/22 to 08/06/22, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and and deficient in total staff for residents on 2 of 7 overnight shifts as follows: -07/31/22 had 9 CNAs for 147 residents on the day shift, required at least 18 CNAs. -07/31/22 had 9 total staff for 147 residents on the evening shift, required at least 15 total staff. -07/31/22 had 6 total staff for 147 residents on the overnight shift, required at least 10 total staff. -08/01/22 had 12 CNAs for 143 residents on the day shift, required at least 18 CNAs. -08/02/22 had 14 CNAs for 142 residents on the day shift, required at least 18 CNAs. -08/02/22 had 13 total staff for 142 residents on	S 560	a. The DON/Designee will review the outcome of the employee recruitment initiatives and report to the administrator on a quarterly basis. b. The DON/Designee will report the progress and/or findings to the QAPI committee monthly for the next three months and assess if further action is necessary.	

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S 560	Continued From page 3	S 560		

the evening shift, required at least 14 total staff.
-08/02/22 had 9 total staff for 142 residents on the overnight shift, required at least 10 total staff.
-08/03/22 had 16 CNAs for 142 residents on the day shift, required at least 18 CNAs.
-08/04/22 had 16 CNAs for 142 residents on the day shift, required at least 18 CNAs.
-08/05/22 had 14 CNAs for 142 residents on the day shift, required at least 18 CNAs.
-08/06/22 had 13 CNAs for 142 residents on the day shift, required at least 18 CNAs.

As per the "Nurse Staffing Report," completed by the facility for the weeks of 11/12/23 to 11/18/23 and 11/19/23 to 11/25/23, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows:

-11/12/23 had 10 CNAs for 137 residents on the day shift, required at least 17 CNAs.
-11/13/23 had 12 CNAs for 137 residents on the day shift, required at least 17 CNAs.
-11/14/23 had 13 CNAs for 137 residents on the day shift, required at least 17 CNAs.
-11/15/23 had 14 CNAs for 137 residents on the day shift, required at least 17 CNAs.
-11/16/23 had 16 CNAs for 139 residents on the day shift, required at least 17 CNAs.
-11/17/23 had 11 CNAs for 139 residents on the day shift, required at least 17 CNAs.
-11/18/23 had 12 CNAs for 139 residents on the day shift, required at least 17 CNAs.

-11/19/23 had 14 CNAs for 137 residents on the day shift, required at least 17 CNAs.
-11/20/23 had 15 CNAs for 137 residents on the day shift, required at least 17 CNAs.
-11/21/23 had 13 CNAs for 137 residents on the day shift, required at least 17 CNAs.
-11/23/23 had 16 CNAs for 139 residents on the

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S 560	Continued From page 4 day shift, required at least 17 CNAs. -11/24/23 had 12 CNAs for 139 residents on the day shift, required at least 17 CNAs. -11/25/23 had 13 CNAs for 139 residents on the day shift, required at least 17 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 (Y2)	DATE OF REVISIT (Y3)
315309	A. Building B. Wing	1/8/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT WHITING	23 SCHOOLHOUSE ROAD WHITING, NJ 08759

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 F0727 Reg. # 483.35(b)(1)-(3) LSC	Correction Completed 01/08/2024	ID Prefix F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 01/08/2024	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	
11/30/2023	☐ 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
061523 Y1	A. Building B. Wing Y2	1/8/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT WHITING	23 SCHOOLHOUSE ROAD WHITING, NJ 08759

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 01/08/2024	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 11/30/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO