STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	**350 OXFORD ROAD OXFORD, NJ 07863**

(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 #: NJ00150311 Census: 79 Sample Size: 6 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by:	F 700		1/14/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 12/22/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	**350 OXFORD ROAD OXFORD, NJ 07863**

(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 700	Continued From page 1 Complaint #: NJ00150311 Based on observations, interviews, medical record review, and review of other pertinent facility documents on 12/1/21 and 12/2/21, it was determined that the facility failed to ensure informed consent was obtained and to follow the facility's policy titled "Side Rails (SR)" for 2 of 6 residents (Residents #2 and #6) reviewed for Side Rails. This deficient practice was evidenced by the following: 1. According to the "ADMISSION RECORD (AR)" form, Resident #2 was admitted to the facility on NJ Exec Order 26 with diagnoses that included but were not limited to: NJ Exec Order 26.4b1. According to the Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4b, Resident #2 had NJ Exec Order 26.4b1 and required extensive assistance from staff with Activities of Daily Living (ADL). The Order Summary Report (OSR) showed an order on NJ Exec Order 26 for half side rails x two (2) to promote NJ Exec Order 26. The Care Plan (CP) revised on NJ Exec Order 26, further showed that Resident #2 had the potential for NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. Interventions included but were not limited to : Resident #2 required encouragement, assistance with use of 2 half side rails to assist with NJ Exec Order 26. The "Side Rail Assessment (SRA)" effective date on NJ Exec Order 26.4b and signed by the Director of Nursing on NJ Exec Order 26 indicated that Resident #2 required the use of 2 half SR as enabler to promote NJ Exec O	F 700	F 770 Bedrails 1. Resident #2 was reassessed for appropriate placement of siderails. Evaluation determined a continued need for support for NJ Exec Order 26.4b1 and safety. Resident's bed fitted with an enabler. Resident # 6 was discharged home prior to plan of correction completion. 2. The facility recognized that all residents have the potential to be affected by this deficient practice. The IDCP TEAM completed an audit of all resident's beds for presence of side rails or enablers. An audit of side rail use, assessments, care plans and orders were completed. Side rail policy was reviewed and revised. Any resident determined to need a side rail(s) consent was obtained. 3. The facility staff education on the implementation of enablers as a bed mobility device and the updated side rail policy was completed. The Director of Nursing/designee along with the rehabilitation director and the IDCP team will review all new/readmissions for the need for of an enabling device. All resident will be reviewed quarterly and as needed for changing needs in bed mobility and safety.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. BUILDING ______ B. WING ______	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	**350 OXFORD ROAD** **OXFORD, NJ 07863**

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F 700	Continued From page 2 NJ Exec Order 26 and to provide support during care. However, the SRA and the Resident's medical record showed no documented evidenced that Resident #2 or the RR gave an informed consent for the use of SR. Review of the facility's "RESIDENT CONCERN FORM (RCF)" filed by Resident #2's Representative (RR) on NJ Exec Order 26.4, showed under "Family concerns...DC [discontinue] of side rails..." Attached with the RCF the undated letter from the RR showed that the RR visited the facility on NJ Exec Order 26.4 and observed the following : -Half side rails on both upper side of the bed. Resident #2 was unable to put either SR down by herself when requested to demonstrate. During the tour of the unit on 12/2/21 at 11:49 am, the surveyor observed Resident #2 was out of bed sitting in a wheelchair watching television (TV). The surveyor observed Resident #2's bed had side rails up on both upper side of the bed. During the interview with the Certified Nursing Assistant (CNA #1, assigned CNA for Resident #2) on 12/1/21 at 11:49 am, she stated that Resident #2's SR were up at all times, especially at night time to prevent the Resident NJ Exec Order 26.4b1. She stated that during the night Resident #2 could get NJ Exec Order 26.4b1 and get out of bed. During an interview with Licensed Practical Nurse (LPN #2) on 12/1/21 at 1:06 pm, she stated that Resident #2 was NJ Exec Order 26.4b1 and to prevent the Resident NJ Exec Order 26.4b1 the SR were up at all times. During an interview with the Director of Nursing (DON) on 12/1/21 at 2:21 pm and 12/2/21 at 9:39 am, she stated that there was no informed	F 700	4. The results of these audits will be reported to the QAPI Committee Quarterly. Date of Completion: 1/14/21	

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	315304	A. BUILDING ______ B. WING ______	C 12/02/2021

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WARREN HAVEN REHAB AND NURSING CENTER	350 OXFORD ROAD OXFORD, NJ 07863

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F 700	Continued From page 3 consent from Resident #2 for the use of SR. She stated that Resident #2 would not NJ Exec Order 26.4b1 and she could not remember if the use of SR were discussed with the RR. She further stated that the facility could have done a better job. However, obtaining the consent was missed. 2. According to the AR form, Resident #6 was admitted to the facility on NJ Exec Order 26.4b with diagnosis that included but was not limited to: NJ Exec Order 26.4b According to the MDS, dated NJ Exec Order 26.4, Resident #6's NJ Exec Order 26.4b1 and required extensive to total assistance from staff with Activities of Daily Living (ADL). The OSR showed an order dated NJ Exec Order 26.4 for 2 half side rails to promote NJ Exec Order 26.4b1. The CP initiated and revised on NJ Exec Order 26.4b, showed that Resident #6 had an ADL NJ Exec Order 26.4b1. The CP further showed that Resident #2 was at NJ Exec Intervention included but was not limited to : use of 2 half side rails. The SRA dated NJ Exec Order 26.4 and the Progress Notes (PN) did not show documented evidenced that Resident #6 gave an informed consent for the use of side rails. During the tour of the unit on 12/1/21 at 9:50 am and 12/2/21 at 9:29 am, Resident #6 was in bed, with 2 half SR up. During the interview with Resident #6 on 12/2/21 at 9:29 am, Resident #6 stated SR were already secured to the bed frame since day 1 of admission. The Resident stated that SR were up	F 700		

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	315304	A. BUILDING ______ B. WING ______	C 12/02/2021

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F 700	Continued From page 4	F 700		

to NJ Exec Order 26.4b1 However, the Resident revealed he/she did not consent to the use of side rails or requested for the side rails.

The facility policy titled "Side Rails" revised 4/29/19, showed "Purpose : To promote a safe environment for all residents while respecting their dignity, right to self-determination and desire to use side rails for their comfort and safety...Responsibility:..Forms: Informed Consent..."

NJAC 8:39 4.1 (a) 3
NJAC 8:39 4.1 (a) 12
NJAC 8:39-27.1(b)

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	62102	A. BUILDING: ______ B. WING ______	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	**350 OXFORD ROAD OXFORD, NJ 07863**

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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: Based on interviews and review of pertinent facility documentation on 12/1/21 and 12/2/21, 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 for 14 of 14 day reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "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 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. The CNAs were responsible for providing direct care to the residents. The surveyor requested staffing for the weeks of 10/24/2021 and 10/31/2021. Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the	S 560	S-560 - Mandatory Access to Care 1) The facility is monitoring acuity and nursing staffing hours and CNA ratios daily. Nursing overtime shifts, bonus shifts, and per diem shifts are being utilized when needed to maintain the required hours and staffing ratios. The facility continues to aggressively recruit, hire and retain nursing staff. 2) The facility recognizes that all residents have the potential to be affected by this deficient practice. The facility will track and log all the results of the facility recruitment and retention efforts. 3) Staffing PIP team has been established and will meet weekly to review current staffing patterns, PPD, CNA ratios, recruitment and retention efforts. The facility does not currently have agency contracts as they report, they have no one in our area. 4) The results of the PIP will be reviewed at the quarterly Quality Assurance Performance Improvement meeting to ensure compliance and to identify any trends or patterns requiring further corrective actions.	1/14/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 12/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	62102	A. BUILDING: ______ B. WING ______	C **12/02/2021**

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S 560	Continued From page 1 following: The facility was deficient in CNA staffing for residents on 13 of 14 day shifts, deficient in CNAs to total staff on 1 of 14 evening shifts, and deficient in total staff for residents on 2 of 14 overnight shifts as follows: - 11/14/21 had 9 CNAs for 78 residents on the day shift, required 10 CNAs. - 11/15/21 had 9 CNAs for 78 residents on the day shift, required 10 CNAs. - 11/16/21 had 9 CNAs for 78 residents on the day shift, required 10 CNAs. - 11/18/21 had 9 CNAs for 77 residents on the day shift, required 10 CNAs. - 11/19/21 had 8 CNAs for 77 residents on the day shift, required 10 CNAs. - 11/20/21 had 8 CNAs for 77 residents on the day shift, required 10 CNAs. - 11/21/21 had 7 CNAs for 77 residents on the day shift, required 10 CNAs. - 11/22/21 had 9 CNAs for 79 residents on the day shift, required 10 CNAs. - 11/23/21 had 8 CNAs for 79 residents on the day shift, required 10 CNAs. - 11/24/21 had 7 CNAs for 78 residents on the day shift, required 10 CNAs. - 11/25/21 had 6 CNAs for 77 residents on the day shift, required 10 CNAs. - 11/25/21 had 5 total staff for 77 residents on the overnight shift, required 6 total staff. - 11/26/21 had 6 CNAs for 77 residents on the day shift, required 10 CNAs. - 11/27/21 had 7 CNAs for 77 residents on the day shift, required 10 CNAs. - 11/27/21 had 4 CNAs to 9 total staff on the evening shift, required 5 CNAs. - 11/27/21 had 4 total staff for 77 residents on the overnight shift, required 6 total staff.	S 560	Completion 01/14/2022	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	62102	A. BUILDING: ______ B. WING ______	C 12/02/2021

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S 560	Continued From page 2 During an interview on 12/2/21 at 12:55 pm, the Administrator and the Director of Nursing, they stated that the facility was aware of the staffing ratios.	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)
315304		6/14/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	350 OXFORD ROAD OXFORD, NJ 07863

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 F0700 Reg. # 483.25(n)(1)-(4) LSC	Correction Completed 01/14/2022	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
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	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
12/2/2021	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
62102 Y1	A. Building B. Wing Y2	6/14/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HAVEN REHAB AND NURSING CENTER	350 OXFORD ROAD OXFORD, NJ 07863

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 01/14/2022	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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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 12/2/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			