PRINTED: 02/15/2022 FORM APPROVED

New Jersey Department of Heal	th

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		061202			09/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
CARE ON	E AT THE HIGHLANDS				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	, NJ 08820 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
S 000	Initial Comments THE FACILITY WAS 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	000	
S 560	8:39-5.1(a) Mandator (a) The facility shall c Federal, State, and lo regulations.	omply with applicable	S 560		10/2/21
	by: Based on interview a documentation, it was failed to maintain the care staff to resident mandated by the Stat evident for 13 out of 7 Findings include: Reference: New Jers (NJDOH) memo, date with N.J.S.A. (New Jers	ey Department of Health ed 01/28/2021, "Compliance ersey Statutes Annotated) um staffing requirements for cated the New Jersey		 No residents were affected. No residents were identified to be affected. Facility will continue to recruit Certific Nurses Aides through incentive program and working with Talent acquisition and Human Resources. Director of Nursing or designee will monitor staffing ratios daily and docum weekly review of daily staffing x 4 week then twice monthly for 2 months to monitor. The DON will present the rest of the audits to the Quality Assurance Performance Improvement Committee review on a monthly basis for 3 months 	ns I ent ks ults for

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

Electronically Signed

STATE FORM

KFX511

TITLE

If continuation sheet 1 of 3

(X6) DATE

10/06/21

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New Jersey Department of Health STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		061202	B. WING		09/20/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
CARE ON	E AT THE HIGHLANDS		AN AVENUE NJ 08820			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTI	ON (X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		
S 560	Continued From page	9 1	S 560			
				The Committee will review and revise plan if needed.	se the	
	One Certified Nurse A residents for the day s	vide (CNA) to every eight shift.				
	fewer than half of all s CNAs, and each direc	ing shift, provided that no staff members shall be ct staff member shall be a CNA and shall perform				
	÷	t shift, provided that each ber shall sign in to work as a				
	the facility for the wee 9/5/21 to 9/11/21, the	offing Report" completed by eks of 8/29/21 to 9/4/21 and staffing to resident ratios minimum requirement of 1 r the day shift as				
	day shift. 8/31/21 had 11 C day shift. 9/1/21 had 9 CN/ day shift.	NAs for 91 residents on the NAs for 91 residents on the As for 91 residents on the As for 91 residents on the				
	day shift. 9/3/21 had 9 CN/ day shift. 9/4/21 had 10 CN day shift.	As for 96 residents on the NAs for 96 residents on the As for 96 residents on the				

New Jersey Department of Health

KFX511

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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 09/20/2021	
		061202				
NAME OF P	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STATE, ZIP CODE			
CARE ON	E AT THE HIGHLANDS		MAN AVENUE , NJ 08820			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETE DATE
S 560	day shift. 9/7/21 had 8 CN day shift.	NAs for 96 residents on the As for 95 residents on the	S 560			
	day shift. 9/9/21 had 9 CN day shift. 9/10/21 had 11 (day shift.	As for 95 residents on the As for 92 residents on the CNAs for 92 residents on the NAs for 92 residents on the				
	NJAC 8:39-5.1(a)					

KFX511