PRINTED: 10/23/2019 FORM APPROVED OMB NO. 0938-0391

| NAME OF PROVIDER OR SUPPLIER CORAL HARBOR REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 2050 SIXTH AVE NEPTUNE CITY, NJ 07753 | | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|--|--------|--|--|--|---|-------------------------------|-------|
| NAME OF PROVIDER OR SUPPLIER CORAL HARBOR REHABILITATION AND HEALTHCARE CENTER (X4) ID PREFIX TAG INITIAL COMMENTS STANDARD SURVEY: 8/22/19 CENSUS: 96 SAMPLE SIZE: 37 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities. F 688 SS=D STREET ADDRESS, CITY, STATE, ZIP CODE 2050 SIXTH AVE NEPTUNE CITY, NJ 07753 STREETADDRESS, CITY, STATE, ZIP CODE 2050 SIXTH AVE NEPTUNE CITY, NJ 07753 SPROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 F 000 F 000 F 000 F 688 STREETADDRESS, CITY, STATE, ZIP CODE 2050 SIXTH AVE NEPTUNE CITY, NJ 07753 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 F 000 F 000 F 000 F 600 F 600 F 600 F 600 F 608 STANDARD SURVEY: 8/22/19 CENSUS: 96 SAMPLE SIZE: 37 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities. F 688 Increase/Prevent Decrease in ROM/Mobility F 688 SS=D SF 688 SS=D STREETADDRESS, CITY, STATE, ZIP CODE 2050 SIXTH AVE NEPTUNE CITY, NJ 07753 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTION SHOULD BE CROSS-REFERE | | 315105 | | B. WING | | 08/22/2019 | 9 |
| PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS STANDARD SURVEY: 8/22/19 CENSUS: 96 SAMPLE SIZE: 37 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities. F 688 SS=D (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 F 000 F 000 F 000 F 000 F 000 F 688 STANDARD SURVEY: 8/22/19 CENSUS: 96 SAMPLE SIZE: 37 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities. Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. | | | | ; | 2050 SIXTH AVE | | |
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| SS=D CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. | | the requirements of 4 | 2 CFR Part 483, Subpart B, | | | | |
| | | | | F 688 | 3 | 9/12/1 | 9 |
| resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and | | §483.25(c)(1) The factoresident who enters the range of motion does range of motion unless condition demonstrate | ne facility without limited not experience reduction in ss the resident's clinical es that a reduction in range | | | | |
| §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. | | motion receives appro | opriate treatment and ange of motion and/or to | | | | |
| §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of Preparation and/or execution of this plan | | receives appropriate sassistance to maintain the maximum practical reduction in mobility is This REQUIREMENT by: | services, equipment, and nor improve mobility with able independence unless a service demonstrably unavoidable. It is not met as evidenced | | Preparation and/or execution of this p | lan | |
| the medical record, it was determined that the facility failed to follow a physician's order for the application of a that provides a barrier between the of correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth in the Statement of | | the medical record, it facility failed to follow application of a that provides | was determined that the a physician's order for the s a barrier between the | | of correction does not constitute an admission or agreement by the Providor of the truth of the facts alleged or conclusion set forth in the Statement of | er | |

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

(X6) DATE

Electronically Signed

09/12/2019

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.

Facility ID: NJ61317

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---|---|--|---|
| 315105 | | | B. WING | | | 22/2019 |
| NAME OF PROVIDER OR SUPPLIER CORAL HARBOR REHABILITATION AND HEALTHCARE CENTER | | | 205 | 50 SIXTH AVE | | |
| (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | ID PREFI TAG | × | | | (X5) COMPLETION DATE |
| residents (Resident # and mobility. The deficient practice following: According to the Adm was admitted to the f medical diagnoses the Review of a Quarterly an assessment tool umanagement of care resident was On 08/16/19 at 11:57 floor and obs in a wheelchair in the nursing station. The limited range of motions surveyor attempted to regarding any device | for 1 of 2 47) reviewed for positioning was evidenced by the hission Record, Resident #47 acility on and had hat included y Minimum Data Set (MDS), hised to facilitate the higher dated reflected the AM, the surveyor toured the herved Resident #47 seated higher day room area next to the higher resident appeared to have had an and resident #47 higher day room area the higher day room area next to the higher day room area ne | F | 688 | Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State Laws require it. Increase/Prevent decrease in ROM/Mobility Resident #47 was re-evaluated by Occupational Therapy and was treated trial an alternative Resident #47 did not have a change in function, alteration in skin integrity or a adverse effect. Resident #47 scare pl was updated to reflect self-removal of the and interventions for nursing staff monitor for removal and replace as needed. All residents requiring have the potential to be affected. All licensed nurses and CNAs will be re-educated by DON/Designee on application and use of accordance with physicians orders, monitoring for placement, proper documentation of application and | to ny lan he if to | |
| or other typ. The survey 08/21/19 at 10:39 AN On 08/19/19 at 1:07 I Resident #47 seated room area. The surv | e of device in the resident's yor observed the same on 1. PM, the surveyor observed in a wheelchair in the dining eyor did not observe | | | audits to visualize placement and observe documentation for residents wutilize The audits will be conducted monthly for 3 months. The results of the audits will be presented to | i ho | |
| | ROVIDER OR SUPPLIER ARBOR REHABILITATIO SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page residents (Resident # and mobility. The deficient practice following: According to the Adm was admitted to the f medical diagnoses the | ARBOR REHABILITATION AND HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 for 1 of 2 residents (Resident #47) reviewed for positioning and mobility. The deficient practice was evidenced by the following: According to the Admission Record, Resident #47 was admitted to the facility on and had medical diagnoses that included Review of a Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated resident was On 08/16/19 at 11:57 AM, the surveyor toured the floor and observed Resident #47 seated in a wheelchair in the day room area next to the nursing station. The resident appeared to have limited range of motion and The surveyor attempted to interview Resident #47 regarding any devices used for his/her | ROVIDER OR SUPPLIER ARBOR REHABILITATION AND HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 For 1 of 2 residents (Resident #47) reviewed for positioning and mobility. The deficient practice was evidenced by the following: According to the Admission Record, Resident #47 was admitted to the facility on and had medical diagnoses that included Review of a Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated reflected the resident was On 08/16/19 at 11:57 AM, the surveyor toured the floor and observed Resident #47 seated in a wheelchair in the day room area next to the nursing station. The resident appeared to have limited range of motion and The surveyor attempted to interview Resident #47 regarding any devices used for his/her and the resident was During that observation, the surveyor did not observe a or other type of device in the resident's The surveyor observed the same on 08/21/19 at 10:39 AM. On 08/19/19 at 1:07 PM, the surveyor observed Resident #47 seated in a wheelchair in the dining room area. The surveyor did not observe | ROVIDER OR SUPPLIER ARBOR REHABILITATION AND HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 F 688 F 688 Continued From page 1 F 688 On 1 of 2 residents (Resident #47) reviewed for positioning and mobility. 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The surveyor did not observe | ROVIDER OR SUPPLIER 315105 B WIND SITESTADDRESS, CITY, STATE, ZIP CODE 2050 SIXTH AVE SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY WIS TER PERCENDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 For 1 of 2 residents (Resident #47) reviewed for positioning and mobility. The deficient practice was evidenced by the following: According to the Admission Record, Resident #47 was admitted to the facility on medical diagnoses that included Review of a Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the manaagement of care, dated medical diagnoses that included Review of a Courterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated medical manag | A BUILDING 315105 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2850 SIXTH AVE REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 For 1 of 2 residents (Resident #47) reviewed for positioning and mobility. The deficient practice was evidenced by the following: According to the Admission Record, Resident #47 was admitted to the facility on medical diagnoses that included Review of a Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated for effected the resident was finited range of motion and for resident was finited range of motion and for resident was finited range of motion and for the surveyor did not observe a or of other type of device in the residents of the surveyor observed Resident #47 medical to be affected. All residents requiring for placement, proper documentation of application and use of application and medical of a pulpication and use of a policy in the resident was finited range of motion and for the surveyor did not observe a or of other type of device in the residents of the surveyor observed the same on 08/21/19 at 11:07 PM, the surveyor observed Resident in the dining room area. The surveyor did not observed residents in the dining room area. The surveyor did not observed residents in the dining room area. The surveyor did not observed residents in the dining room area. The surveyor did not observed residents in the dining room area. The surveyor did not observed residents who utilize for further review and action as appropriate. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|---------------------|--|---------------------------------|-------------------------------|----------------------------|
| | 315105 | | B. WING _ | | | 08/22/2019 | |
| NAME OF PROVIDER OR SUPPLIER CORAL HARBOR REHABILITATION AND HEALTHCARE CENTER | | | , | STREET ADDRESS, CITY, STATE, ZIP O 2050 SIXTH AVE NEPTUNE CITY, NJ 07753 | CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT | TION SHOULD BE THE APPROPRIA | | (X5) COMPLETION DATE |
| F 688 | On 08/21/19 at 12:49 PN On 08/19/19 at 11:49 the Electronic Medic Resident #47. The E order dated, 03/23/1 morning care, and to discomfort and skin evening shift as a pr Review of Resident i initiated on self-care performance The Cl intervention for ' Review of Resident i Administration Reco order that required th day and evening app day. From 08/16/19 revealed that the num was applied On 08/21/19 at 1:10 the Certified Nursing assigned to care for stated that she was in if the con On 08/21/19 at 12:5 the 08/21/19 TAR for reflected that the num | and 12:49 PM, and again on M. 5 AM, the surveyor reviewed al Record (EMR) for EMR revealed a physician's 9, to after ocheck for the check for the property of the arrow of the foliation of the folication of the | Fé | 588 | | | |

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ' ' | PLE CONSTRUCTION G | , , , | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------------------|---|-----------|----------------------------|--|
| | | 315105 | B. WING | | | 08/22/2019 | |
| NAME OF PROVIDER OR SUPPLIER CORAL HARBOR REHABILITATION AND HEALTHCARE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2050 SIXTH AVE NEPTUNE CITY, NJ 07753 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 688 | the Licensed Practic Resident #47. LPN required extensive a however, the reside The surveyor inquire provided to the resic reviewed the EMR is surveyor and stated that was supposed there was Resident #47 removed the his/her Review of Resident revealed there was Resident #47 removed the his/her Review of Resident revealed there was Resident #47 removed the his/her Review of Resident revealed there was Resident #47 removed the his/her was Re | PM, the surveyor interviewed cal Nurse (LPN #1) regarding #1 stated that the resident assistance with ADLs; and could feed him/herself. The difference of the state and complete the resident had a complete to his/her LPN #1 observed the LPN #1 obs | F 68 | 38 | | | |

| | TEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|---|---|---------------------|--|-------------------------------|----------------------------|
| | | 315105 | B. WING | | 08/ | 22/2019 |
| NAME OF PROVIDER OR SUPPLIER CORAL HARBOR REHABILITATION AND HEALTHCARE CENTER | | | • | STREET ADDRESS, CITY, STATE, ZIP CODE 2050 SIXTH AVE NEPTUNE CITY, NJ 07753 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 688 | appropriateness for The noresistant to use and of is able to pull device shown to F strap to hold in slippage Recommend AM aide thoroughly daily to m build-up in During a subsequent 11:14 AM, in the pres Director of Nursing (I RDCS reiterated that when staff a The RDCS also state TAR when they applied the substitution of the residence of the put it had no nurses. On 08/22/19 at 11:16 | advanced the reflected, "patient is due to lack of support strap off. An improved the hab Manager with secure area more easily without the staff clean inimize odor and bacteria " interview at on 08/22/19 at the sence of the Administrator, DON) and survey team, the the resident removed the the resident removed the the the to Resident the regularly removed the to be the documented by the AMM, the DON stated the documented that Resident | F 68 | 8 | | |
| F 730 SS=D | | leview-12 hr/yr In-Service | F 73 | 0 | | 9/12/19 |
| | The facility must com of every nurse aide a months, and must pre education based on t | ovide regular in-service he outcome of these raining must comply with the | | | | |

| A. BUILDING COMPLETED 315105 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE CORAL HARBOR REHABILITATION AND HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) | OLIVILIY | O T OIT MEDIO TITE & | WEDIO/ ND CEITTIOEC | | | | OIVID ITC | 7. 0000 0001 |
|--|-----------|--|--|---------|-------|---|--------------------------------------|--------------|
| This REQUIREMENT is not met as evidenced by: Based on interview and review of facility for imaniar requirements. This deficient practice was evidenced by the following: Review of the in-service records provided by the facility for five randomly selected CNAs revealed that two of the five did not have the required Dementia training by their employment anniversary date. STREET ADDRESS, CITY, STATE, ZIP CODE 2059 SIXTH AVE NEPTUNE CITY, NJ 07753 STREET ADDRESS, CITY, STATE, ZIP CODE 2059 SIXTH AVE NEPTUNE CITY, NJ 07753 FROWIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 730 Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State Laws require it. Nurse Aide Performance Review- 12hr/yearly In-service CNA #1 and CNA #2 received annual Dementia training by their employment anniversary date. 1. CNA #1 had a date of hire of CNA #1 and CNA #2 received annual Dementia training on Dementia from All residents have the potential to be affected. Dementia training is scheduled to be provided on a bi-monthly basis throughout the year for all facility staff, including all | ` ' | | ` ' | 1 ' ' | i i | | | |
| CORAL HARBOR REHABILITATION AND HEALTHCARE CENTER 2050 SIXTH AVE NEPTUNE CITY, NJ 07753 | | | 315105 | B. WING | | | 08/ | 22/2019 |
| SUMMARY STATEMENT OF DEFICIENCIES DEPOSITION AND HEALTHCARE CENTER | NAME OF P | ROVIDER OR SUPPLIER | | | S1 | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| F 730 Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to provide the required annual Dementia training for 2 of 5 Certified Nurse Aides (CNA) that were reviewed for mandatory CNA education requirements. This deficient practice was evidenced by the following: Review of the in-service records provided by the facility for five randomly selected CNAs revealed that two of the five did not have the required Dementia training by their employment anniversary date. 1. CNA #1 had a date of hire of was no documented training on Dementia from EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 730 F 730 Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or execution of this plan of correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or execution of this plan of correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions of Federal and State Laws require it. Nurse Aide Performance Review-12hr/yearly In-service CNA #1 and CNA #2 received annual Dementia training on 9/11/19 which was conducted b | CORAL H | ARBOR REHABILITATIO | N AND HEALTHCARE CENTER | | | | | |
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| Dementia-Certified Physician. On 08/22/19 at 9:30 AM, the Administrator provided a staff In-service sign-in sheet, dated for the Topic: Dementia Care. The Administrator confirmed that neither CNA #1 nor CNA #2 attended the in-service. On 08/22/19 at 12:30 PM, the Regional Director of Clinical Services provided evidence of annual Dementia training for CNAs #3, #4 and #5 and stated there was no evidence of Dementia training for CNAs #1 and #2. | F 730 | This REQUIREMENT by: Based on interview a documentation, it was failed to provide the ritraining for 2 of 5 Cerithat were reviewed for requirements. This deficient practical following: Review of the in-service following: Review of the in-service following: Review of the five did Dementia training by anniversary date. 1. CNA #1 had a dat was no documented a staff In-service for the Topic Administrator confirm CNA #2 attended the On 08/22/19 at 12:30 of Clinical Services pince for stated there was no documented for stated there was no documented the con 08/22/19 at 12:30 of Clinical Services pince for stated there was no documented for stated there was no documented the con 08/22/19 at 12:30 of Clinical Services pince for stated there was no documented there was no documented the control of | and review of facility and review of facility sequired annual Dementia riffied Nurse Aides (CNA) or mandatory CNA education are was evidenced by the rice records provided by the rily selected CNAs revealed do not have the required their employment. There training on Dementia from the of the first of the composition | F | 730 | of correction does not constitute an admission or agreement by the Provide of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State Laws require it. Nurse Aide Performance Review-12hr/yearly In-service CNA #1 and CNA #2 received annual Dementia training on 9/11/19 which was conducted by a Dementia-Certified Physician. All residents have the potential to be affected. Dementia training is scheduled to be provided on a bi-monthly basis through the year for all facility staff, including a CNAs. The training will be conducted to Dementia-Certified Physician. DON/Designee will conduct audits of 5 employee files to monitor compliance or required annual Dementia training. The audits will be conducted monthly for 3 months. The results of the audits will be presented to the monthly QAPI commifor further review and action as | er f s e nout II by a with e | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | | |
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| 315105 | | | B. WING | | 08/22/2019 | | | |
| NAME OF PROVIDER OR SUPPLIER CORAL HARBOR REHABILITATION AND HEALTHCARE CENTER | | | 2 | STREET ADDRESS, CITY, STATE, ZIP CODE 2050 SIXTH AVE NEPTUNE CITY, NJ 07753 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | | | |
| F 921 SS=D | CFR(s): 483.90(i) §483.90(i) Other En The facility must pro sanitary, and comforesidents, staff and This REQUIREMEN by: Based on observat of facility documents the facility failed to renvironment, specif housekeeping close residents. This deficient practif following: On 08/20/19 at 4:42 Resident #85, unsurarea in the back left courtyard. On 08/21/19 at 9:13 the courtyard area wobserved emerging on the previous day which contained the piece of wood, a we ground, a large snow the side of the build (typically used to ha against a white fence butt, varied sized br | nitary/Comfortable Environ vironmental Conditions ovide a safe, functional, rtable environment for the public. IT is not met as evidenced ion and interviews and review ation, it was determined that maintain a safe and sanitary ically a courtyard and a at that was accessible by ce was evidenced by the PM, the surveyor observed pervised, emerge from an a corner of the facility AM, the surveyor observed where Resident #85 was from during the observation A walkway led to an area a following: a large door size athered wood pallet on the w shovel propped up against ing, two large black hooks and decorations) propped up te, two white cups, a cigarette anches and many brown debris on the ground. | F 921 | Preparation and/or execution of this please of correction does not constitute an admission or agreement by the Provide of the truth of the facts alleged or conclusion set forth in the Statement or Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State Laws require it. F921 D All debris in the courtyard area noted of the Statement of Deficiencies was discarded on 8/21/19 by the Director of Environmental Services/designee. All items in the courtyard storage room housekeeping closet noted on the Statement of Deficiencies were sanitized or discarded as indicated, removed from the floor and stored safely and sanitarily A new storage lock that can't be manual unlocked was placed on the courtyard storage room closet to ensure it remain secure at all times. This was completed by 9/13/19 by the Director of Environmental Services/designee. All residents have the potential to be affected by this practice. The Director of Environmental Services. | er f m y. ally | | | |
| | rear area of the resi | 3 AM, two surveyors toured the dent courtyard with the Administrator confirmed the | | Environmental Services/designee rounded on the entire facility to inspect any areas that were not maintained in a | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | ATE SURVEY MPLETED |
|---|---|--|---------------------|--|---|----------------------------|
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| F 921 | should be clean. Sfacility residents had courtyard. On 08/21/19 at 9:3 the surveyors obselecated in the rear Administrator state housekeeping storopened the unlock Administrator and Administrator and Administrator state locked. Inside the various debris on trincluded the follow closet, two large willings in the two bundles located next to a hadministrator state have been stored of the two bundles located next to a hadministrator state have been stored those linen bundle and bottles of water linen that were open Administrator state washcloths. The washcloths. The washcloths are conclused to the conclused should not lever the conclused should not lever the conclusion of | tions and stated that the area she also confirmed that the ave access to that area of the ave and an exterior metal door of the courtyard. The add the door led to a age closet. The surveyor ed door in the presence of the second surveyor. The add the door should have been closet, the surveyors observed the floor and items which ring: On the left side of the white wrapped bundles of new the Administrator, were stored are additional bundles of directly on top of and to the rear stored on the floor, which were ousekeeping mop bucket. The add that the linen should not on the floor. Directly opposite and stored on top of a pallet for, there were two bundles of an and exposed to air. The add the bundles were new avashcloths were stored in close the bags of ice melt, adjacent to not cleaners and amongst other and Administrator stated she was addition of the closet and the book like that. | F9 | safe and sanitary manner. In noted were immediately ad New daily cleaning schedul implemented for the courty areas noted on the Stateme Deficiencies. Included in the to confirm that the courtyar closet door is secure. In-see was provided by the Administrator/designee to a environmental staff on the imaintaining a safe and san environment, including the the courtyard and closet are sanitary and the importance the new daily cleaning sche The Administrator/Designer round weekly on the courty area noted on the Statemen Deficiencies to ensure that maintained in a safe and sa Any issues noted will be adfindings will be presented a QAPI committee meeting for and monitoring until the corindicates otherwise. | Idressed. Iles were ard and closet ent of e schedule is d storage room ervice education all importance of itary need to keep ea safe and e of adhering to edule. e will randomly ard and closet nt of they are being anitary manner. Idressed. All at the monthly or follow up | |

| | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ' ' | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| F 921 | provided a copy of ar which revealed that t cleaned on 08/15/19, residents had access the courtyard where | aning schedule. The SA n Outside Ground Clean Log, he Back Courtyard was . The SA confirmed that the s to the area in the back of the debris was observed and n the current state of the | FS | 921 | | | |