STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315105	A. BUILDING _____ B. WING _____	C 12/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL HARBOR REHABILITATION AND HEALTHCARE CENTER	2050 SIXTH AVE NEPTUNE CITY, NJ 07753

(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 # NJ00169890 Census: 96 Sample Size: 3 The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
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 records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F 842		2/2/24

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

Electronically Signed | 02/05/2024

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
	315105	A. BUILDING _____ B. WING _____	C 12/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL HARBOR REHABILITATION AND HEALTHCARE CENTER	2050 SIXTH AVE NEPTUNE CITY, NJ 07753

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F 842	Continued From page 1 (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 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315105	A. BUILDING _____ B. WING _____	C 12/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL HARBOR REHABILITATION AND HEALTHCARE CENTER	2050 SIXTH AVE NEPTUNE CITY, NJ 07753

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F 842	Continued From page 2 C #: NJ00169890 Based on interviews, medical record review, and review of other pertinent facility documents on 12/28/23, it was determined that the facility staff failed to consistently document in the "Documentation Survey Report" (DSR) the Activities of Daily Living (ADL) status and care provided to the resident according to facility policy and protocol for 2 of 3 residents (Resident #1 and Resident #2) reviewed for documentation. This deficient practice was evidenced by the following: 1. According to the facility "Admission Record (AR)," Resident #2 was admitted on [redacted] with diagnoses that included but were not limited to: [redacted] The Minimum Data Set (MDS), an assessment tool, dated [redacted], revealed a Brief Interview of Mental Status (BIMS) of [redacted] which indicated the resident's cognition was [redacted] and the resident needed assistance with ADLs including NJ Exec. Order 26:4.b.1 [redacted]. Review of Resident #2's DSR (ADL Record) and the progress notes (PN) for the month of [redacted] lack any documentation to indicate that the care for NJ Exec. Order 26:4.b.1 [redacted] was provided and/or the resident refused care on the following dates and shifts; 7:00 am-3:00 pm shift on NJ Exec. Order 26:4.b.1 [redacted] and 1[redacted] to	F 842	F842 As noted in 12/28/24 survey, Resident #1 and #2 lacked documentation in medical record for ADL and progress notes of care provided for both residents on several dates. An audit of resident #1 and #2 were completed by Director of nursing to see which shift and staff member was responsible to complete the POC for each day. Individual meeting held by Director of nursing and each staff member 1:1 to educate on importance of documentation at end of each shift and reviewed regulation with them. Discussed if any changes in ADL function noted which no changes noted in either resident #1 or #2. Director of nursing or designee will monitor daily resident #1 and #2 for 2 weeks on POC documentation related to ADL's and then biweekly for 1 month to ensure compliance. A complete audit was completed by nursing management team on all residents to identify specific dates, shifts or staff member trends. Education provided and completed by 12/29/23 to all nursing staff with return demonstration to ensure knowledge of how to complete. To ensure compliance, nurse supervisor will look at completion report for each resident and make general announcement to nursing assistants one hour prior to end of shift as a reminder to complete the ADL tasks. At end of shift, report will be looked at and any tasks that are not completed will be addressed with	

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	315105	A. BUILDING _____ B. WING _____	C 12/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 3 NJ Exec. Order 26:4.b.1. 3:00 pm-11:00 pm shift on NJ Exec. Order 26:4.b.1 to NJ Exec. Order 26:4.b.1, and NJ Exec. Order 26:4.b.1 to NJ Exec. Order 26:4.b.1. 11:00 pm-7:00 am shift on NJ Exec. Order 26:4.b.1, NJ Exec. Order 26:4.b.1, and NJ Exec. Order 26:4.b.1 to 1 NJ Exec. Order 26:4.b.1. 2. According to the facility AR, Resident #1 was admitted on [redacted], with diagnoses that included but was not limited to: [redacted] The MDS, dated [redacted], revealed a BIMS of [redacted] which indicated the resident's [redacted] was [redacted] and the resident needed assistance with dressing and supervision with other ADLs including NJ Exec. Order 26:4.b.1 [redacted]. Review of Resident #1's DSR (ADL Record) and the progress notes (PN) for the month of NJ Exec. Order 26:4.b.1, lack any documentation to indicate that the care for NJ Exec. Order 26:4.b.1 [redacted] was provided and/or the resident refused care on the following dates and shifts; 7:00 am-3:00 pm shift on NJ Exec. Order 26:4.b.1 to NJ Exec. Order 26:4.b.1, NJ Exec. Order 26:4.b.1 to NJ Exec. Order 26:4.b.1, and NJ Exec. Order 26:4.b.1 3. 3:00 pm-11:00 pm shift on NJ Exec. Order 26:4.b.1, NJ Exec. Order 26:4.b.1 to NJ Exec. Order 26:4.b.1 to NJ Exec. Order 26:4.b.1, and NJ Exec. Order 26:4.b.1. 11:00 pm-7:00 am shift on NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 to 1 NJ Exec. Order 26:4.b.1	F 842	specific nursing assistant and supervisor will assist with any difficulties nursing assistant having with completing tasks. During clinical meeting daily, the Director of nursing or designee will look at report to ensure completion and compliance with ADL task documentation from prior day. A QAPI was put in place to measure completion percentage and to evaluate process to ensure to remain in compliance. Currently ADL task documentation is in compliance.	

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	315105	A. BUILDING _____ B. WING _____	C 12/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL HARBOR REHABILITATION AND HEALTHCARE CENTER	**2050 SIXTH AVE NEPTUNE CITY, NJ 07753**

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F 842	Continued From page 4 During an interview with the surveyor on 12/28/23 at 2:50 pm, the Director of Nursing (DON) said that the ADL tasks are completed by the CNA and there should be no blanks. The DON further stated that there is no way of knowing if the task was done if it was not documented. Review of a facility policy titled "Activities of Daily Living (ADLs), Supporting", with a revised date of March 2018, reflected "The resident's ability to participate in ADLs and the support provided during ADL care and resident-specific tasks will be documented each shift by Certified Nursing Assistants in the medical record ..." NJAC 8:39-35.2(d)(9)	F 842		

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
	061317	A. BUILDING: _____ B. WING _____	C 12/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL HARBOR REHABILITATION AND HEAL	2050 SIXTH AVE NEPTUNE CITY, NJ 07753

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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		
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 #: NJ00169890 Based on interview and review of pertinent facility documentation on 12/28/23, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 14 of 14 day shifts and 4 of 14 overnight shifts as follows: This deficient practice had the potential to affect all residents.	S 560	S560 As noted in 12/28/24 survey staffing ratios were not met 14 of 14 days on day shift and 4 of 14 on overnight shift. Facility reviewed all open shifts with recruiter noted in DOH visit. Facility continues to hire staff and tracks weekly progress. Facility has a recruiter who assists with ad placement and updating as needed or weekly. Weekly meetings with recruiter to discuss open positions and review of ad placement. Facility chat allows all staff and recruiter to	2/2/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/05/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL HARBOR REHABILITATION AND HEAL	2050 SIXTH AVE NEPTUNE CITY, NJ 07753

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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 as 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 of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide 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. As per the "Nurse Staffing Report" completed by the facility for the 2 weeks of staffing from 12/10/2023 to 12/23/2023, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift and one direct care staff member to every 10 residents for the evening shifts as documented below: 1. For the week of staffing from 12/10/2023 to 12/23/2023, the facility was deficient in CNA staffing for residents in 14 of 14 day shifts and deficient in total staff for residents on 4 of 14 overnight shifts as follows:	S 560	communicate in real time to communicate arrival of applicant, hiring status or decline of position with explanation. Offers made at time of interview with applicant and sign on bonuses offered at various rates based on need of shift. Facility completed wage analysis with surrounding Nursing homes to ensure wages are competitive. Mass mailing to surrounding area nurses and nursing assistants completed to advertise open positions. Facility offers tuition reimbursement, competivitive insurance benefits, 401k with matching, on the job training for new graduates, overtime opportunities and bonuses. Facility has contract with local C N A schools where students complete their clinical rotation at Coral Harbor and job offers made when students graduate. Facility also hires potential staff to become C N A□s and will pay for class in order to get certification. Daily staffing meetings are held to discuss staffing ratio and to adjust as needed to be in compliance with regulations. Director of nursing will monitor staffing daily and adjust staffing ratio per state guidelines per facility census. Staffing meetings to be held daily to ensure proper state ratios held. Director of nursing will record staffing ratio per day and present to QAPI team monthly. To ensure compliance a QAPI was initiated and will be reviewed monthly at QAPI meeting to measure percentage of compliance of month with staffing ratio.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061317	A. BUILDING: _____ B. WING _____	C 12/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 2 -12/10/23 had 7 CNAs for 103 residents on the day shift, required at least 13 CNAs. -12/10/23 had 6 total staff for 103 residents on the overnight shift, required at least 7 total staff. -12/11/23 had 8 CNAs for 99 residents on the day shift, required at least 12 CNAs. -12/12/23 had 7 CNAs for 100 residents on the day shift, required at least 12 CNAs. -12/13/23 had 7 CNAs for 101 residents on the day shift, required at least 12 CNAs. -12/14/23 had 7 CNAs for 102 residents on the day shift, required at least 12 CNAs. -12/15/23 had 6 CNAs for 102 residents on the day shift, required at least 13 CNAs. -12/15/23 had 6 total staff for 102 residents on the overnight shift, required at least 7 total staff. -12/16/23 had 9 CNAs for 100 residents on the day shift, required at least 12 CNAs. -12/17/23 had 8 CNAs for 100 residents on the day shift, required at least 12 CNAs. -12/18/23 had 8 CNAs for 98 residents on the day shift, required at least 12 CNAs. -12/19/23 had 8 CNAs for 96 residents on the day shift, required at least 12 CNAs. -12/19/23 had 6 total staff for 96 residents on the overnight shift, required at least 7 total staff. -12/20/23 had 8 CNAs for 99 residents on the day shift, required at least 12 CNAs. -12/21/23 had 8 CNAs for 98 residents on the day shift, required at least 12 CNAs. -12/22/23 had 9 CNAs for 98 residents on the day shift, required at least 12 CNAs. -12/23/23 had 7 CNAs for 98 residents on the day shift, required at least 12 CNAs. -12/23/23 had 6 total staff for 98 residents on the overnight shift, required at least 7 total staff.	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)
315105	A. Building B. Wing	2/12/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL HARBOR REHABILITATION AND HEALTHCARE CENTER	2050 SIXTH AVE NEPTUNE CITY, NJ 07753

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 F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 02/02/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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	
12/28/2023	☐ 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 (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
061317	A. Building B. Wing	2/12/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL HARBOR REHABILITATION AND HEALTHCARE CENTER	2050 SIXTH AVE NEPTUNE CITY, NJ 07753

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 02/02/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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 12/28/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			