STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315275	A. BUILDING _____ B. WING _____	C 11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORD HEALTHCARE & REHABILITATION CENTER	**963 OCEAN AVE LAKEWOOD, NJ 08701**

(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 155581, NJ 155665, NJ 158865, NJ 159099, NJ 159345, NJ 161697, NJ 161302, 164557 Survey Date: 11/3/2023 Census: 98 Sample: 20+4 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other	F 583		11/4/23

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

Electronically Signed | 11/13/2023

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.

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F 583	Continued From page 1 than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide privacy and promote dignity during medication administration for 3 of 8 residents observed (Residents #16, #34 and #93) on 1 of 2 nursing units and for 1 of 3 nurses observed. This deficient practice was evidenced by the following: During the medication administration observation of the [redacted] unit on 10/27/23 at 7:39 AM, the surveyor observed the Registered Nurse (RN) administer medications to Resident #16. The surveyor observed the resident awake and seated in their wheelchair in the doorway of their room. The RN sanitized their hands, donned gloves, and without providing Resident #16 with privacy the RN cleaned Resident #16's [redacted] with an [redacted] and performed a [redacted] *Ex Order 26. 4B1* [redacted]. The door to the resident's room remained opened and the resident continued to be visible from the hallway as the	F 583	F583 1. Rn identified in statement of deficiencies was immediately re-educated on Residents rights, privacy, and dignity. The facility spoke with Residents #16, #34 and #93 to reassure them that the facility will ensure that all residents are always treated with privacy and dignity. 2. All residents have the potential to be affected by this deficient practice. 3. The ADON & Staff educator completed an education to all staff on resident rights, privacy and dignity. The facility will receive feedback from the resident council meeting for the next 3 months to see if any resident privacy or dignity issues are present at the facility. 4. Staff educator or designee will complete privacy and dignity audits weekly x4 and then monthly x3. Results of these audits will be reported by the Director of Nursing and the Administrator at the QAPI meetings. QAPI meetings are held Quarterly at the facility.	

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F 583	Continued From page 2 RN performed the test. The surveyor reviewed the medical records of Resident #16 which revealed the following: Resident #16 was admitted with diagnoses which included but were not limited to: Ex Order 26. 4B1 [redacted]. Review of Resident #16's Quarterly Minimum Data Set (MDS), an assessment tool, dated NJ Exec. Order 26:4.b.1, revealed that the resident had a Ex Order 26. 4B1 [redacted] of " " out of 15" which indicated that the resident's Ex Order 26. 4B1 [redacted]. Review of Resident #16's Ex Order 26. 4B1 [redacted] reflected a Ex Order 26. 4B1 for Ex Order 26. 4B1 [redacted] as per sliding scale: if NJ Exec. Order 26:4.b.1 [redacted] Ex Order 26. 4B1 before meals for [redacted]; if Ex Order 26. 4B1 [redacted] is less than NJ Exec. Order 26:4.b.1 notify the [redacted]. On 10/27/23 at 8:09 AM, the surveyor observed Resident #34 seated in their wheelchair in the hallway outside of their room. The RN asked Resident #34 to go to their room. The RN put gloves on, cleaned Resident #34's [redacted] with an Ex Order 26. 4B1 and performed a Ex Order 26. 4B1 [redacted]. The door to the resident's room remained opened and the resident continued to be visible from the hallway as the RN then administered Ex Order 26. 4B1 [redacted] to each [redacted] and then used an [redacted] scrub pad to each [redacted].	F 583		

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F 583	Continued From page 3 The surveyor reviewed the medical records of Resident #34 which revealed the following: Resident #34 was admitted with diagnoses which included but were not limited to: Ex Order 26. 4B1 [redacted]. Review of Resident #34's Quarterly MDS, dated NJ Exec. Order 26:4.b.1, revealed that Resident #34 had a [redacted] of [redacted] out of 15" which indicated that the resident's Ex Order 26. 4B1 [redacted]. Review of Resident #34's October 2023 [redacted] reflected a [redacted] for Ex Order 26. 4B1 [redacted] if less than 70 or greater than 400 notify the MD; [redacted] for Ex Order 26. 4B1 [redacted] instill one gtt in both [redacted] two times a day for NJ Exec. Order 26:4.b.1 Provide Privacy; Ex Order 26. 4B1 [redacted] apply to both Ex Order 26. 4B1 two times a day for NJ Exec. Order 26:4.b.1 On 10/27/23 at 8:16 AM, the surveyor observed the RN enter Resident # 93's room. Resident #93 was awake in bed. The RN stated that the resident was [redacted] but communicated by using a communication board and using thumbs up and thumbs down. The RN put gloves on, cleaned Resident #93's [redacted] with an Ex Order 26. 4B1, and performed a Ex Order 26. 4B1 [redacted]. The RN pulled up Resident #93's gown exposed his/her adult Ex Order 26. 4B1 [redacted], and administered [redacted] of [redacted] to Resident #93's [redacted] in the Ex Order 26. 4B1 [redacted]. The door remained open and the resident continued to be visible from the hallway. At that time, the surveyor asked the RN to step out of Resident #93's room and asked the RN if she should have provided the resident with privacy by pulling the resident's curtain and	F 583		

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F 583	Continued From page 4 closing the door. The RN replied, "yes, but [the resident] is so far back and nobody is usually back here." The surveyor reviewed the medical records of Resident #93 which revealed the following: Resident #93 was admitted with diagnoses which included but were not limited to *Ex Order 26. 4B1* [redacted].	F 583		
	Review of Resident #93's Quarterly MDS dated [redacted], revealed that Resident #93 had a [redacted] of [redacted] out of 15" which indicated that the resident's *Ex Order 26. 4B1* [redacted].			
	Review of Resident #93's October 2023 [redacted] reflected a [redacted] dated 9/9/23 for *Ex Order 26. 4B1* [redacted] per sliding scale: if 151-200 = 2 units; 201-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units; 351-400 =10 units, *Ex Order 26. 4B1* three times a day for [redacted] call [redacted] if less than 70 or greater than 400.			
	During an interview with the surveyor on 10/27/23 at 12:07 PM, the RN stated that she should have provided privacy by closing the residents' door during care, *Ex Order 26. 4B1* [redacted], administration of *Ex Order 26. 4B1* [redacted], and medications given via the *Ex Order 26. 4B1* [redacted]. The RN acknowledged that she did not provide privacy during those times.			
	On 11/2/23 at 11:25 AM, the surveyor team met with the Regional Administrator, Licensed Nursing			

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F 583	Continued From page 5 Home Administrator (LNHA), Director of Nursing (DON), Regional Nurse, and Infection Preventionist Nurse to discuss the above observations and concerns. The DON stated that the RN should provide privacy during care, treatments, and medication administration. Review of a facility policy titled, Resident Rights, dated January 2023, included but was not limited to; Employees shall treat all Residents with kindness, dignity, and respect. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include ...privacy and confidentiality. Residents are entitled to exercise their rights and privileges to the fullest extent possible.	F 583		
F 658 SS=D	NJAC 8:39-4.1(a)(12) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documents, it was determined that the facility failed to follow professional standards of clinical practice with medication administration for 1 of 8 residents (Resident #93) observed for medication pass. This deficient practice was evidenced by the following:	F 658	F658- RN identified on the Statement of Deficiencies was provided with education by facility educator. A competency evaluation of this RN was immediately completed on Ex Order 26. 4B1 administration by facility educator and by the pharmacy consultant. Resident #93 family and MD	11/4/23

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F 658	Continued From page 6 Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing a medical regimen as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 10/27/23 at 8:16 AM, the surveyor observed as the Registered Nurse (RN) prepared medications to be administered via a Ex Order 26. 4B1 [redacted] to Resident # 93. The RN removed the resident's Ex Order 26. 4B1 [redacted] from the Ex Order 26. 4B1 cart and checked them against the Ex Order 26. 4B1 [redacted]. The RN removed the tablets from the Ex Order 26. 4B1, put them in a	F 658	were notified of this incident. All staff have the potential of being affected by this. Facility ADON or educator gave an in-service education on Ex Order 26. 4B1 administration to all nurses in the facility. ADON or Educator will randomly select 2 nurses weekly X 3 months and perform a competency evaluation. Issues identified will be referred to the Director of Nursing and Administrator for corrective action. The outcomes of the medication professional standards evaluations will be reported at the facility QAPI meeting for further follow-up. QAPI is held quarterly at the facility.	

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F 658	Continued From page 7 small plastic bag, and crushed the three Ex Order 26. 4B1 together. The RN administered the Ex crushed Ex Order 26. 4B1 together via the Ex Order 26. 4B1 . During an interview with the surveyor on 10/27/23 at 12:07 PM, the RN stated that it was her regular practice to crush and administer all the tablets together via a Ex Order 26. 4B1. The surveyor asked the RN what the facility's policy was for administering Ex Order 26. 4B1 via a Ex Order 26. 4B1. The RN replied she wasn't sure. The surveyor asked the RN if she had received a Ex Order 26. 4B1 administration in service and competency. The RN replied she had received both but wasn't sure who provided the training or completed the competency. On 11/2/23 at 11:25 AM, the surveyor team met with the Regional Administrator, Licensed Nursing Home Administrator (LNHA), Administrator in training, Director of Nursing (DON), Regional Nurse, and Infection Preventionist Nurse to discuss the above observations and concerns. The DON stated that the facility's policy was to administer medications individually one at a time via the g-tube. Review of the facility's "Administering Medications" policy, revised April 2023, did not address the administration of medications via a gastrostomy tube. Review of the Facility's Competency Validation for Medication Administration reflected ...Respect resident's right to privacy ...when administering medication through a g-tube do not mix several medications together ...flush tube between each medication with at least 5 ccs of water.	F 658		

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F 658	Continued From page 8 Review of the RN's Competency Validation for Medication Administration reflected that the Infection Prevention Nurse (IPN) had completed a competency with the RN during her orientation on [redacted]	F 658		
F 880 SS=D	NJAC 8:39-27.1(a) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		11/4/23

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F 880	Continued From page 9 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 880	F880- Handwashing	

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F 880	Continued From page 10 and review of facility documentation, it was determined that the facility failed to maintain infection control standards and procedures to address the risk of infection transmission by failing to perform proper hand hygiene for 1 of 3 nurses who administered Ex Order 26. 4B1 to 1 of 8 residents (Resident # 93) observed during Ex Order 26. 4B1 administration. This deficient practice was evidenced by the following: On 10/27/23 at 8:16 AM, the surveyor observed the Registered Nurse (RN) administer Ex Order 26. 4B1 and medications via a Ex Order 26. 4B1 to Resident # 93. The surveyor then observed the RN remove her gloves to wash her hands. The RN applied soap and lathered her hands for seven seconds out of the stream of running water. She rinsed her hands and turned off the faucet with her bare hands then dried her hands with a paper towel. The surveyor reviewed the medical records of Resident #93 which revealed the following: Resident #93 was admitted with diagnoses which included but were not limited to Ex Order 26. 4B1 . Review of Resident #93's Quarterly MDS dated NJ Exec. Order 26, revealed that Resident #93 had a Ex Order 26. 4 of [redacted] out of 15" which indicated that the resident's Ex Order 26. 4B1 . During an interview with the surveyor on 10/27/23	F 880	RN identified on the Statement of Deficiencies was provided with handwashing reinforcement education by facility Ex Order 26. 4B1 . A competency evaluation of this RN was immediately completed. All staff have the potential of being affected by this. Facility Ex Order 26. 4B1 [redacted]/educator gave an in-service education on CDC Handwashing requirements to all employees in the facility. Facility Ex Order 26. 4B1 or designee will randomly select 3 employees weekly X 3 months and perform a Handwashing competency evaluation. Issues identified will be referred to the Director of Nursing and Administrator for corrective action. The outcomes of Handwashing competency evaluations will be reported at the facility QAPI meeting for further follow-up. QAPI is held at the facility on a quarterly basis.	

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F 880	Continued From page 11	F 880		

at 12:07 PM, the RN stated that the process for handwashing included lathering hands together with soap and water for 20 seconds and that the whole process should take 30 seconds. The RN stated that the importance of handwashing was to prevent the spread of infection.

On 11/2/23 at 11:25 AM, the surveyor team met with the Regional Administrator, Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Nurse, and Infection Preventionist Nurse to discuss the above observations and concerns.

During an interview with the Infection Preventionist Nurse (IPN) on 11/2/23 at 1:36 PM, the IPN stated that the RN should have washed her hands following the facility handwashing policy which instructed to vigorously lather hands with soap and scrub them for at least 20 seconds. The IPN further stated that the RN should have turned the faucet off with a clean paper towel.

A review of the facility's Handwashing/Hand Hygiene policy, revised December 2022 reflected ...this facility considers hand hygiene the primary means to prevent the spread of infections ...Employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions:before and after direct resident care; before and after performing any invasive procedure (e.g., fingerstick blood sampling) ...vigorously lather hands with soap and rub them together, creating friction to all surfaces, for at least 15-20 seconds covering all surfaces of the hands and fingers ...rinse hands thoroughly under running water ...dry hands thoroughly with paper towels and then turn off

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(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 880	Continued From page 12 faucets with a clean dry paper towel. A review of the U.S. Centers for Disease Control and Prevention (CDC) guidelines, Clean Hands Count for Healthcare Providers, reviewed 1/8/2021, included, "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry." NJAC 8:39:19.4 (a)(n),27.1(a)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061519	A. BUILDING: _____ B. WING _____	C 11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORD HEALTHCARE & REHABILITATION	963 OCEAN AVE LAKEWOOD, NJ 08701

(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) COMPLETE DATE
S 000	Initial Comments Complaint # NJ 00155581, NJ 00158865, NJ00159345 The facility is 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 # NJ 00155581, NJ 00158865, NJ00159345 Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: 1. Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance	S 560	S560 Staffing 1. Efforts to hire facility staff will continue until there are adequate staff to serve all residents. Until that time, the facility will utilize staffing agencies to fill any open spots in the schedule. 2. All residents have the potential to be affected by this practice. 3. Contracts with additional staffing agencies have been secured to supplement facility staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience,	11/4/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 11/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061519	A. BUILDING: _____ B. WING _____	C 11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORD HEALTHCARE & REHABILITATION	963 OCEAN AVE LAKEWOOD, NJ 08701

(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) COMPLETE DATE
S 560	Continued From page 1 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. 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. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 05/29/2022 to 06/12/2022, 09/25/2022 to 10/23/2022, 11/13/2022 to 11/19/2022, 02/05/2023 to 02/11/2023, 02/19/2023 to 02/25/2023, 05/28/2023 to 06/03/2023, revealed the facility was deficient in CNA staffing for residents as follows: 1. For the 3 weeks of Complaint staffing from 05/29/2022 to 06/12/2022, the facility was deficient in CNA staffing for residents on 3 of 21 day shifts as follows: -05/29/22 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -06/11/22 had 11 CNAs for 96 residents on the	S 560	online job listings, job fairs, shift differentials and referral bonuses are being utilized to become more competitive in the marketplace. 4. The Administrator or Designee will review staffing schedules weekly to ensure adequate staffing for all shifts. The results of these reviews will be submitted to the QAPI committee through the remainder of 2023. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. QAPI is held on a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061519	A. BUILDING: _____ B. WING _____	C 11/03/2023

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CONCORD HEALTHCARE & REHABILITATION	963 OCEAN AVE LAKEWOOD, NJ 08701

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S 560	Continued From page 2 day shift, required at least 12 CNAs. -06/12/22 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. 2. For the 5 weeks of Complaint staffing from 09/25/2022 to 10/23/2022, the facility was deficient in CNA staffing for residents on 4 of 35 day shifts as follows: -10/03/22 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -10/06/22 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -10/08/22 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs. -10/16/22 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. 3. For the week of Complaint staffing from 02/05/2023 to 02/11/2023, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -02/05/23 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -02/07/23 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. 4. For the week of Complaint staffing from 02/19/2023 to 02/25/2023, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -02/24/23 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -02/25/23 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. 5. For the week of Complaint staffing from 05/28/2023 to 06/03/2023, the facility was	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061519	A. BUILDING: _____ B. WING _____	C 11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 3 deficient in CNA staffing for residents on 4 of 7 day shifts as follows: -05/28/23 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. -05/29/23 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. -05/30/23 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs. -05/31/23 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs. During an interview with the surveyor on 10/31/23 at 10:09 AM, the staffing coordinator stated they were aware of the staffing ratio requirements.	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315275 (Y1)	A. Building B. Wing (Y2)	12/1/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORD HEALTHCARE & REHABILITATION CENTER	963 OCEAN AVE LAKEWOOD, NJ 08701

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 F0583 Reg. # 483.10(h)(1)-(3)(i)(ii) LSC	Correction Completed 11/04/2023	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 11/04/2023	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 11/04/2023
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	
11/3/2023	☐ 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
061519 Y1	A. Building B. Wing Y2	12/1/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORD HEALTHCARE & REHABILITATION CENTER	963 OCEAN AVE LAKEWOOD, NJ 08701

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 11/04/2023	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 11/3/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315275	A. BUILDING **01** B. WING _____	**11/03/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORD HEALTHCARE & REHABILITATION CENTER	**963 OCEAN AVE** **LAKEWOOD, NJ 08701**

(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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 11/01/2023. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/01/23 was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Concord Healthcare and Rehabilitation Center is a one-story building that was built in 1988, and is composed of Type V - 111 protected construction. The facility is divided into six - smoke zones. The generator does approximately 100 % of the building as per the Maintenance Director. The current occupied beds are 91 of 120.	K 000		
K 223 SS=F	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:	K 223		11/7/23

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

Electronically Signed | 11/13/2023

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.

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	315275	A. BUILDING **01** B. WING _____	**11/03/2023**

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CONCORD HEALTHCARE & REHABILITATION CENTER	**963 OCEAN AVE** **LAKEWOOD, NJ 08701**

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K 223	Continued From page 1 * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the fire rated door assemblies from the kitchen to the dining area in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.3.2.5. This deficient practice had the potential to affect all 91 residents. Findings include: An observation on 11/01/23 at 1:14 PM revealed that the fire rated door assemblies leading to the dining room were binding and not closing properly. During an interview at the time of the observation, the Maintenance Director and Administrator were present and verified the doors did not close properly. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 223	K223 1. **Door Inspection and Maintenance: ** - An immediate audit was conducted to inspecting all doors with self-closing devices throughout the facility to Ensure that doors function properly and that self-closing devices are in good working condition. 2. **Immediate Repairs: ** - Door closer identified was immediately ordered for replacement. On Nov 7th the full door with the door closer mechanism was replaced. 3. **Staff Training: ** - Maintenance staff were educated on how to properly inspect check doors and self-closing devices. Any self-closing devices identified as needing repairs or adjustments will immediately be repaired. All residents have the potential to be affected by this. 4. **Documentation of Inspections: ** - The Administrator or Director of Maintenance will Keep detailed records of door inspections, including dates and any issues discovered.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315275	A. BUILDING **01** B. WING _____	**11/03/2023**

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CONCORD HEALTHCARE & REHABILITATION CENTER	**963 OCEAN AVE** **LAKEWOOD, NJ 08701**

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K 223	Continued From page 2	K 223	- The Administrator or Director of Maintenance will conduct monthly audits on self-closing devices and review these audits to identify patterns or recurring problems. 5. **Ongoing Training and Awareness: ** - All staff at the facility are educated annually in life safety regulations which include self-closing devices. 6. **Regulatory Compliance Check: ** - The Administrator or Director of Maintenance will conduct monthly life safety audits on all fire smoke doors and self-closing devices to ensure the facility is in accordance with NFPA standards. The results of these audits will be communicated with the QAPI team on a quarterly basis.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced	K 372		11/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315275	A. BUILDING **01** B. WING _____	**11/03/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORD HEALTHCARE & REHABILITATION CENTER	**963 OCEAN AVE** **LAKEWOOD, NJ 08701**

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K 372	Continued From page 3 by: Based on observation and interview, the facility failed to ensure penetrations in the fire barrier in the attic was protected by a system or material capable of restricting the penetration of fire in accordance with NFPA 101 Life Safety Code (2012 edition) 8.3.5.1. This deficient practice had the potential to affect all 91 residents who resided at the facility. Findings include: An observation on 11/01/23 at 1:45 PM of the fire barrier, located in the attic above rooms 11 and 12 of the B-wing, revealed a 12" x 8" piece of metal that was pushed into the wall. Continued observation revealed a 1" x 1" hole with three wires which was not sealed with fire caulk. During an interview at the time of the observation, the Maintenance Director confirmed the penetrations in the smoke barriers were not protected by a system or material capable of restricting the penetration of fire. NJAC 8:39-31.1(c), 31.2(e)	K 372	K372 1. **Immediate Inspection: ** - The Administrator and Director of Maintenance Conducted a comprehensive inspection of all building spaces to identify any deficiencies related to smoke barriers as per NFPA standards. 2. **Repairs: ** - The identified areas in the attic were repaired on 11/3/23. The maintenance director and Administrator inspected the area to ensure it meets NFPA standards. 3. **Staff Training: ** - All maintenance personnel were educated on the importance of maintaining smoke barriers and the impact on resident safety. All residents have the potential of being affected by this. 4. **Documentation of Barrier Integrity: ** - The Administrator or Director of Maintenance will complete monthly audits on smoke barrier walls for penetration. Any identified penetration will be repaired immediately. Identified issues will be documented. - The Administrator will review these records monthly to identify patterns or recurring problems. 5. **Regulatory Compliance Assurance: ** - The Administrator or Director of Maintenance will conduct monthly life safety audits on all fire smoke barriers to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315275	A. BUILDING **01** B. WING _____	**11/03/2023**

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K 372	Continued From page 4	K 372	ensure the facility is in accordance with NFPA standards. The results of these audits will be communicated with the QAPI team on a quarterly basis.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315275 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	12/1/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORD HEALTHCARE & REHABILITATION CENTER	963 OCEAN AVE LAKEWOOD, NJ 08701

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0223	Correction Completed 11/07/2023	ID Prefix Reg. # NFPA 101 LSC K0372	Correction Completed 11/04/2023	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
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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 11/3/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			