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	315312	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON RIDGE HEALTHCARE AND REHABILITATION	**94 STEVENS ROAD TOMS RIVER, NJ 08755**

(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 This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint # NJ00153752 Survey Date: 7/27/23 Census:167 Sample: 34 + 3 closed records 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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of medical records and other facility documentation, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS), an assessment tool for 3 of 34 residents reviewed (Resident #74, #101, and #69).	F 641	F 641 SS=D Accuracy of Assessments I. Corrective action(s)accomplished for resident(s)affected: " Facility failed to accurately complete Minimum Data Set assessment tool for the resident #74, #101, #69. The MDS	8/30/23

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

Electronically Signed | 08/06/2023

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 641	Continued From page 1 This deficient practice was evidenced by the following: On 07/17/23 at 10:53 AM, the surveyor observed Resident #74 sitting on the side of the bed in the room. There was an EX Order 26.4B1 with EX Order 26.4B1 on the floor. Review of Resident #74 Admission Record, the resident was admitted to the facility on EX Order 26.4B1 Medical diagnoses included, but not limited to EX Order 26.4B1 Review of the quarterly MDS, dated EX Order 26.4B1, EX Order 26, revealed Resident #74 had a Brief Interview of Mental Status of EX Ord, meaning the resident was EX Order 26.4B1. Under Section EX Orde Special Procedures and Treatments was blank, meaning the resident did not wear EX Order 26.4B1 as a resident at the facility. Review of the physician orders showed an order for EX Order 26.4B1 at EX Order 26.4B1, an active order dated EX Order 26.4B1 On 07/17/23 at 11:57 AM, the surveyor observed Resident #101 in the bed. There was an EX Order 26.4B1 EX Order 26.4B1 on the floor with EX Order 26.4B1. The surveyor asked the resident if he/she wore the EX Order 26.4B1 and the resident said, EX Order 26.4B1 EX Order 26.4B1." Review of the quarterly MDS dated EX Order 26.4B1, the resident was readmitted to the facility again in EX Order 26.4B1. The resident had a Brief Interview of Mental Status of EX Order meaning Resident #101 was	F 641	assessments for the affected residents were modified immediately to reflect proper documentation. II. Residents identified having the potential to be affected and corrective action taken: " The deficient practice has the potential to affect all residents residing in the facility. Review of all MDS assessments section O Procedures and Treatments the area for Ex.Order 26.4(b)(were reviewed to ensure accurate coding. Only one resident #69 Ex.Order 26.4(b)(1 in the facility and his annual MDS assessment Section Ex.O was modified to reflect current Ex.Order 26.4(b)(1) use. III. Measures have been put into place to ensure the deficient practice will not recur: " Education to MDS coordinator was rendered to include the importance of thoroughly reviewing the medical records prior to completion of MDS assessments as well as completing MDS assessment coding accurately. " All MDS assessments for the residents utilizing Ex.Order 26.4(b)(1) were audited and modified as appropriate for section O Procedures and Treatments the area for Ex.Order 26.4(b)(use. " Collection data sheets for MDS assessments were modified to reflect Ex.Order 26.4(b)(and Ex.Order 26.4(b)(1) use. " The updated information has been integrated into standard orientation training for new MDS coordinators and	

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F 641	Continued From page 2 EX Order 26.4B1. Medical diagnoses included, but were not limited to EX Order 26.4B1 Review of the quarterly MDS, dated EX Order 26.4B under section EX O, Procedures and Treatments the area for EX Order 26.4B1 was left blank, meaning the resident did not wear EX Order 26.4B1 as a resident at the facility. Review of the physician orders showed an order for EX Order 26.4B1 an active order dated EX Order 26.4B1 On 07/26/23 at 10:54 AM, a surveyor interviewed the Minimum Data Set Coordinator (MDSC). The surveyor asked who was responsible for filling out sections of the Minimum Data Set (MDS), and the MDSC said the Social Worker or Activities department filled out section F, nursing completed section J, the dietician completed section K, and therapy completed parts of section O. The departments will enter the data into the MDS themselves. The Director of Nursing oversees the completion of all of the MDS. The MDSC told the surveyor it was extremely important to be accurate for residents and for the state to see "how we are doing". The MDSC also stated that they use the MDS to track how the residents are doing to see if there are significant changes or if therapy referrals are needed to work on for resident care and improvement. 2. On 07/17/23 at 10:37 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) on the North nursing unit. The LPN/UM stated the facility is smoke free, however, there was one resident (Resident #69) who was "grandfathered in" and was able to	F 641	agency MDS coordinators. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: " The DON/Designee together with MDS coordinator will conduct monthly MDS assessment audits for section O Procedures and Treatments the area for Ex.Order 26.4(b)(1) use and section J for current Ex.Order 26.4(b)(1) use monthly x 3 month then quarterly x2 quarters. " The MDS coordinator will report audit findings in QAPI meeting quarterly to QA team to determine if additional monitoring is required.	

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F 641	Continued From page 3 remain the only EX Order 26.4B1 resident in the facility. On 07/17/23 at 11:34 AM, the surveyor observed Resident #69 in their room relaxing in bed. The resident informed the surveyor that he/she had EX Order 26.4B1 since the age of EX Order and usually EX Order 26.4B1 EX Order 26.4B1 The resident further informed that the facility holds on to the EX Order 26.4B1, but the resident can Ex.Order 26.4(b)(1) . Review of Resident #69 Admission Record, the resident was admitted to the facility in EX Order 26.4B EX Order 26. Medical diagnoses included, but not limited to EX Order 26.4B1 . Review of the annual MDS, dated EX Order 26.4B1 EX Order 26, revealed Resident #69 had a Brief Interview of Mental Status of EX Ord out of 15, meaning the resident was EX Order 26.4B1 Under Section EX O EX Order 26.4B1 Use, the assessment was answered No, indicating the resident did not use EX Order 26.4B1 Review the resident's medical record contained a "EX Order 26.4B1" between Resident #69 and the facility signed by the resident and witnessed by the North unit's LPN/UM and dated EX Order 26.4B1 Review of nursing progress notes included a "7 day lookback" note dated EX Order 26.4B1 by the LPN/UM stating " ...resident goes outside to EX Order 26.4 e ...continues to be a EX Order 26.4B1." A second "7 day lookback" nursing note dated EX Order 26.4B1 included "Resident goes	F 641		

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F 641	Continued From page 4 outside to [EX Order 26.4B1] various times of the night ..." On 7/26/23 at 10:54 AM, the surveyor interviewed the MDSC who stated this resident had been [EX Order 26.4B1] for "quite a while," and the resident was still [EX Order 26.4B1] at the time of the completion of this annual MDS. The MDSC stated they infrequently have agency staff assist with MDS completions, and that may have been the reason for the inaccurate [EX Order 26.4B1] assessment for this resident, and after surveyor inquiry, this MDS was modified to reflect a "yes" for [Ex.Order 26.4(b)(1)]	F 641		
F 656 SS=D	NJAC 8:39-11.2 (e)1 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		8/30/23

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F 656	Continued From page 5 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Complaint #NJ153752 Based on interviews and review of the closed medical record, it was determined that the facility failed to develop and implement a comprehensive, person-centered care plan which included interventions to ensure that a resident's preference not be cared for by [redacted] aides was honored. This deficient practice was identified for 1 of 37 residents (Resident #211) reviewed for care plan development.	F 656	F 656 SS=D Development/Implement Comprehensive Care Plan I. Corrective action(s)accomplished for resident(s)affected: " The facility failed to develop and implement a comprehensive, person-centered care plan which included intervention to ensure that a resident□s preference not to be cared for by [redacted] aids was honored for resident #211. The	

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F 656	Continued From page 6 This deficient practice was evidenced by: Review of Resident #211's Admission Record (an admission summary) revealed that the resident was admitted to the facility in EX Order 26.4B1 with diagnosis which included but were not limited to: EX Order 26.4B1 . Review of Resident #211's admission Minimum Data Set (MDS), an assessment tool dated EX Order 26.4B1, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of EX Or out 15, which indicated that the resident was EX Order 26.4B1 Further review of the MDS indicated that the resident required Ex.Order 26.4(b)(1) Review of Section of the MDS EX Order 26.4B1 l, revealed that the resident had an EX Order 26.4B1 and was always EX Order 26.4B1 Review of Resident #211's Care Plan revealed an entry that was initiated on EX Order 26.4B1, which specified that the resident had a diagnosis of EX Order 26.4B1 he focus of the care plan entry concluded with, EX Order 26.4B1". Further review	F 656	resident was DC from the facility on Ex.Order 26.4(b)(1), there are no corrections possible to be made for this resident at this time. II. Residents identified having the potential to be affected and corrective action taken: " The deficient practice has the potential to affect all residents in the facility. The audit was completed to review the care plans for the residents that voiced a preference not to be cared for by a EX Order 26 C NA, none of the resident were affected by this deficient practice. III. Measures have been put into place to ensure the deficient practice will not recur: " The nurse educator in-serviced all unit managers, and unit secretary on the importance to include any personal requests such as not to be cared for by a EX Order 26 C NA to the CNA assignment sheets, Care Profile and C NA Care Tasks immediately after the care preference was voiced by the resident. " Licensed nursing staff were in-serviced on the importance to follow resident□s person -centered care plan and to honor residents□ preferences such as not to be cared for by EX Order 26 aids. " The care plans for the residents that voiced a preference not to be cared for by a EX Order 26 C NA were reviewed and were updated as appropriate. " The Care Profiles, C NA Care Tasks and C NA assignments for the residents that voiced a preference not to be cared for by a EX Order 26 C NA were reviewed and	

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F 656	Continued From page 7 of the goals and interventions/tasks sections of the Care Plan failed to specify how the facility ensured that EX Order 26.4B1 were assigned to the resident in accordance with the resident's Care Plan. Review of the Progress Notes within Resident #211's closed electronic health record, revealed a Nurse's Note dated EX Order 26.4B1, that was signed by the Assistant Director of Nursing (ADON) and revealed the following: "Unit Manager, Director of Social Services, and ADON reviewed careplan [sic]; updated as needed. ...Careplan [sic.] remains appropriate at this time. On 07/24/23 at 11:05 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that if a resident requested not to have a EX Order 26.4B1 provide care, then the Unit Clerk/Secretary was responsible to make sure that the request was placed on the CNA Assignment Sheet. The CNA explained that the assignment may then have to be adjusted to ensure that the resident's preference was honored. The CNA further stated that the request would also be passed on in report by nursing or the outgoing CNA. On 07/24/23 at 11:09 am, the surveyor interviewed the Secretary who stated that she worked at the facility for one year in June. She stated that nursing advised her of all resident special requests, and she was responsible to place the requests on the CNA Assignment Sheet. On 07/24/23 at 11:46 AM, the surveyor interviewed the Licensed Practical Nurse (LPN)	F 656	were updated as appropriate. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: " The unit manager/designee will conduct audits of C NA Care Tasks, Care Profiles and C NA assignments for the residents that have person-centered care plans to honor residents preferences not to be cared for by EX Order 26.4B1 C NAs daily x7, then weekly x4, then monthly x3 month, then quarterly x2 to make sure they are in compliance. " The DON /designee will review above-mentioned audit data with QAPI committee for additional recommendations and follow up and report at the quarterly QAPI meeting to discuss with QA team if there is a need for additional monitoring.	

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who stated that a resident request not to have a EX Order 26.4B1 was reported to the Secretary who was responsible for making the CNA Assignments and scheduling.

On 07/24/23 at 11:51 AM, the Secretary provided the surveyor with 2022 CNA Assignment Sheets which failed to contain CNA Assignment Sheets that corresponded to the dates that Resident #211 resided at the facility.

On 07/24/23 at 12:19 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that she had worked at the facility since 2012 and served in her current role as LPN/UM for one month. She stated that if a resident requested not to have a EX Order 26.4B1 provide care, then she would communicate with social services, update the resident's care plan and place the resident's preference on the CNA Assignment Sheet.

On 07/24/23 at 12:27 PM, the surveyor interviewed the Social Worker who stated that she worked at the facility for four years. She stated that she had not had an instance where a EX Order 26.4B1 resident refused to be cared for by EX Order 26 CNAs. The SW stated that if she encountered this situation she would direct the resident's preference to the Unit Manager, Director of Nursing (DON), and Administrator and assist the resident to file a grievance if indicated.

On 07/25/23 at 11:26 AM, the surveyor interviewed the ADON who stated that she assisted in Care Plan development. She stated that either the UM or Secretary informed the EX Order 26.4B1 were not to be assigned to a

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particular resident or that assignments were switched to honor a resident preference that was Care Planned. The ADON stated that the preference could be placed on the CNA Assignment Sheet or on a sign behind the nurse's station at the desk. The ADON stated that if a [redacted] was accidentally assigned to the resident, then the resident would be interviewed and evaluated to ensure the resident was comfortable. The ADON was unable to state why she documented in the Nurse's Notes on 04/06/22, that she reviewed Resident #211's Care Plan and denied that the entry was in reference to [redacted] being assigned to the resident.

On 07/26/23 at 10:33 AM, in a later interview with the LPN/UM, she accessed Resident #211's electronic health record and demonstrated that the resident's Plan of Care (POC) Dashboard was updated with Special Instructions: [redacted] The LPN/UM also showed the surveyor that a [redacted] CNA was assigned to the resident on [redacted] and signed that [redacted] performed [redacted] care at 3:41 PM, Ex.Order 26.4(b)(1) at 3:41 PM, Ex.Order 26.4(b)(1) at 3:41 PM, and Ex.Order 26.4(b)(1) at 5:23 PM. The LPN/UM stated that the [redacted] CNA did not document that any care was rendered thereafter. The LPN/UM stated that no [redacted] aide should have been placed on the resident's assignment. The LPN/UM stated that a caregiver should only sign for the tasks that they actually completed.

On 07/26/23 at 11:27 AM, the surveyor attempted to interview the [redacted] CNA in question who was not available for interview.

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F 656	Continued From page 10 On 07/26/23 at 11:27 AM, the surveyor interviewed the DON and the Administrator in the presence of the survey team. The Administrator stated that chances were that the [redacted] CNA provided care to Resident #211 as evidenced by the tasks that [redacted] signed out in the POC on [redacted]. The Administrator further stated that the [redacted] CNA might have also charted for another aide. The DON stated that if the resident's Care Plan specified No [redacted] Aides on [redacted], then the request should have been placed on the CNA Assignment Sheets prior to [redacted] when the entry was first documented, according to CNA Assignment Sheets that the DON provided. On 07/27/23 at 9:10 AM, in a later interview with the DON, she provided the surveyor with printed copies of Resident #211's CNA Task History dated 04/02/22, and she explained that the [redacted] CNA documented that [redacted] provided personal care to the resident which included Ex.Order 26.4(b)(1) [redacted] and dining. The DON stated that the CNA's signature indicated that [redacted] rendered all services that [redacted] signed for. Review of an undated facility policy, "Comprehensive Person-Centered Care Plan" revealed the following: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal	F 656		

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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 656	Continued From page 11 representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The IDT includes: The Attending Physician; A license [sic.] nurse who has responsibility for the resident; A nurse aide who has responsibility for the resident;...The resident and resident's legal representative... Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; ...Reflect the resident's expressed wishes regarding care and treatment goals; Review of the facility's "Resident Rights" (May 2023) revealed the following: ...To be treated with courtesy, consideration, and respect for your dignity and individuality... NJAC 8:39-11.2, 13/2(a)	F 656		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a 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	F 688		8/30/23

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F 688	Continued From page 12 of motion is unavoidable; and §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. §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 record review, it was determined that the facility failed to provide a Ex.Order 26.4(b)(1) [redacted] for 1 of 2 residents (Resident #103) that were reviewed for Range of Motion (ROM). This deficient practice was evidenced by the following: The surveyor observed Resident #103 with a EX Order 26.4B1 [redacted] on 7/18/23 at 12:40 PM, on 07/19/23 at 9:50 AM, on 07/20/23 at 10:32 AM, on 07/20/23 at 12:38 PM, and on 07/21/23 at 11:49 AM. When interviewed by the surveyor on 7/21/23 at 11:55 AM, the South Unit Manager stated that Resident # 103 should have been wearing a EX Orde [redacted] but did not have one in his/her EX Order 26.4B1 [redacted] as ordered. According to the medical record Resident # 103	F 688	F 688 SS=D Increase/Prevent Decrease in ROM/Mobility I. Corrective action(s)accomplished for resident(s)affected: " The facility failed to provide a device to address the Ex.Order 26.4(b)(1) for resident #103. A EX Order 26.4B1 was reapplied immediately on EX Order 26.4B1 [redacted]. Resident was reevaluated, MD notified, and Ex.Order 26.4(b)(1) [redacted] completed. Resident care plan was updated. II. Residents identified having the potential to be affected and corrective action taken: " The deficient practice has the potential to affect all residents in the facility. The audit was of the residents that have a MD order for Ex.Order 26.4(b)(1) [redacted] or any Ex.Order 26.4(b)(1) to prevent Ex.Order 26.4(b)(1) was completed to ensure they were wearing their Ex.Order 26.4(b)(1) as per	

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F 688	Continued From page 13 was admitted with a diagnosis that included but was not limited to [redacted]. The annual minimum dated set (MDS) (an assessment tool) dated [redacted] reflected that this resident was [redacted]. On 07/19/23 at 12:30 PM, the surveyor reviewed a copy of the resident's physician orders. A physician's order, dated [redacted], indicated that Resident # 103 should be wearing a [redacted], [redacted] at all times as tolerated. On 07/19/23 at 12:30PM, the surveyor reviewed a copy of the resident's interdisciplinary plan of care. It indicated use of a [redacted]/ if not available may use [redacted] On 07/27/23 at 10:02 AM, the surveyor reviewed the facility provided policy for [redacted] application which was reviewed on 7/2023. The policy reflects 6. apply [redacted] as per orders. NJAC 8:39-27.2(m)	F 688	orders. The care plans of the residents wearing [redacted] were updated. None of the other residents were affected by this deficient practice. III. Measures have been put into place to ensure the deficient practice will not recur: " Licensed nursing staff were in-serviced on the facilities policy of following physician orders regarding [redacted] devices to prevent [redacted] as well as resident care plans. " The residents that use [redacted] or other [redacted] to prevent [redacted] were checked to ensure that physicians orders were followed, and [redacted] or [redacted] were in place as per orders. " The care plans of the residents that use [redacted] or other [redacted] to prevent [redacted] were updated as needed. " The Care Task and C NA assignment sheets were updated to reflect the use of [redacted] and [redacted]. " The DON provided education to unit managers and unit secretary regarding updates of the Care Tasks and C NA assignments sheets to reflect the use of [redacted] and [redacted]. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: " The unit manager/designee will	

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F 688	Continued From page 14	F 688	conduct audits for all residents that have care plans and MD orders for [redacted] to prevent [redacted] daily x7, then weekly x4, then monthly x3 month, then quarterly x2 to make sure they are being worn as per orders. " The restorative C NA will conduct audits weekly continuously for the residents that have care plans and MD orders for [redacted] to prevent [redacted] and address findings in weekly restorative meetings. " The above-mentioned audit data will be reviewed by unit manager/designee and reported at the quarterly QAPI meeting to QA team to determine if there is a need for additional monitoring.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to a.) store respiratory equipment in a way to prevent contamination, and b.) assess a resident's [redacted] way to	F 695	F 695 SS=D Respiratory/Tracheostomy Care and Suctioning I. Corrective action(s)accomplished for resident(s)affected:	8/30/23

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F 695	Continued From page 15 monitor a persons EX Order 26.4B1 level) as ordered by the physician. This deficient practice was for 1 of 2 residents reviewed for Ex.Order 26.4(b)(1) (Resident #74) and was evidenced by the following: a.) On 07/17/23 at 10:52 AM, during the initial tour of the facility, the surveyor observed Resident #74 was in bed with eyes open. The surveyor observed an EX Order 26.4B1 on the floor next to the resident's bed. At the time of the observation, the resident was not wearing the EX Order 26.4B1 The surveyor observed that the EX Order 26.4B1 EX Order 26.4B1 was wrapped up around the handle of the EX Order 26.4B1 and not in a bag. On 07/18/23 at 10:54 AM, the surveyor reviewed Resident #74 physician orders which showed an order for EX Order 26.4B1 EX Order 26.4B1 at bedtime, and another order to monitor the resident's EX Order 26.4B1 every shift and notify the physician if less than or equal to Ex.Ord This was an active order dated . Review of the Admission Record Resident #74 was admitted to the facility on EX Order 26.4B1. Medical diagnoses included, but not limited to EX Order 26.4B1 Resident #74 had a Brief Interview of Mental Status of EX Ord, meaning the resident was EX Order 26.4B1. On 07/18/23 at 12:11 PM, the resident was observed sitting on the side of the bed having lunch. The resident was not wearing EX Order 26.4B1 and the EX Order 26.4B1 was on the floor next to	F 695	" The facility failed a) store respiratory equipment in a way to prevent contamination b) assess a resident□s Ex.Order 26.4(b)(1) as ordered by the physician. Resident #74 was given new EX Order 26.4B1 immediately dated with current date and bag for storage. Resident□s #74 EX Order 26.4B1 was assessed immediately, MD was notified, and new orders were obtained. Resident care plan was updated. II. Residents identified having the potential to be affected and corrective action taken: " The deficient practice has the potential to affect all residents residing in the facility. The orders for the residents that use Ex.Order 26.4(b)(were audited for accuracy and to ensure that physicians orders were followed. The Ex.Order 26.4(b)(1) for the residents that use Ex.Order 26.4(b)(was checked to ensure proper labeling and storage. III. Measures have been put into place to ensure the deficient practice will not recur: " Licensed nursing staff was in-serviced on Ex.Order 26.4(b)(1) dating and proper storage as well as the policy Ex.Order 26.4(b)(1) and Ex.Order 26.4(b)(1) Products. " Licensed nursing staff nurses were in-serviced on checking Ex.Order 26.4(b)(1) as per MD orders. " The care plans for the residents that use Ex.Order 26.4(b)(were updated.	

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F 695	Continued From page 16 the bed turned off. The EX Order 26.4B1 was wrapped up in a circle and tucked in the handle of the EX Order 26.4B1, the EX Order 26.4B was not in a bag. On 07/19/23 at 12:15 PM, the surveyor observed the resident sitting on the side of the bed. The resident was not wearing EX Order 26.4B1 during observation. Resident #74 told the surveyor that he/she wears EX Order 26.4B1 at night. The EX Order 26.4B1 was connected to the EX Order 26.4B1 and the EX Order 26.4B was wrapped up on top of the humidity bottle. The EX Order 26.4B was not in a bag. On 07/19/23 at 12:28 PM, the surveyor interviewed Licensed Practical Nurse/LPN (LPN #1) regarding storing of EX Order 26.4B1 when not being used by a resident. LPN#1 replied, "It should be kept in a plastic bag". The surveyor asked why it should be in a plastic bag and LPN #1 said, "Sanitary reasons". The surveyor showed LPN#1 Resident #74 EX Order 26.4B1 and LPN#1 said, "It should be in a bag". On 07/19/23 at 12:50 PM, the surveyor interviewed LPN #2 regarding the storage of EX Order 26.4B1. The surveyor asked LPN #2 how EX Order 26.4B1 was stored for a resident when not in use and LPN #2 responded, "In a bag for sanitary reasons and to just keep it clean". b.) On 07/18/23 at 10:54 AM, the surveyor reviewed Resident #74 physician orders which showed an order for EX Order 26.4B1 and another order to monitor the residents EX Order 26.4B1 every shift and notify the physician if less than or equal to Ex.Order 26.4(b)(1). This was an active order dated EX Order 26.4B1	F 695	" The orders for the residents that use Ex.Order 26.4(b)(were audited for accuracy and to ensure that physicians orders were followed. " The Ex.Order 26.4(b)(tubing for all the residents that use Ex.Order 26.4(b)(1) was checked to ensure proper labeling and storage. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: " The unit manager/designee will conduct audits for all residents on Ex.Order 26.4(b)(daily x7, then weekly x4, then monthly x3 month to determine that all residents that use Ex.Order 26.4(b)(1) tubing is dated and stored properly. " The unit manager/designee will conduct audits for all residents on Ex.Order 26.4(b)(that have physician order to check Ex.Order 26.4 daily x7, then weekly x4, then monthly x3 month to determine that all physician orders are being followed. " IP nurse will conduct random audits weekly x4, monthly x3 and then quarterly x2 to determine that all residents that use Ex.Order 26.4(b)(1) is dated and stored properly. An audit review and a monthly report will be submitted to the Infection Prevention and Control Committee. " The above-mentioned audit data will be reviewed by unit manager/designee and IP nurse at the quarterly QAPI meeting with QA team to determine if additional monitoring is required.	

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F 695	Continued From page 17	F 695		

On 07/18/23 at 11:00 AM, the surveyor reviewed Resident #74 care plan which had a focus of potential for EX Order 26.4B1 related to EX Order 26.4B1 status and a diagnosis of EX Order 26.4B1 EX Order 26.4B1. The care plan was initiated on EX Order 26.4B1 with a revision date of EX Order 26.4B1 Included in the interventions was to provide EX Order 26.4B1 as ordered and monitor EX Order 26.4B1 and EX Order 26.4B1 sounds every shift.

On 07/18/23 at 11:07 AM, the surveyor reviewed the EX Order 26.4B1 checks for EX Order 26.4B1 which showed the following:

7/2/2023 10:33	Ex.Order 26.4B1 %	Room Air
6/2/2023 12:38	Ex.Order 26.4B1 %	Room Air
6/1/2023 09:24	Ex.Order 26.4B1 %	Room Air
5/31/2023 10:48	Ex.Order 26.4B1 %	Room Air
5/30/2023 23:16	Ex.Order 26.4B1 %	Room Air
5/30/2023 12:52	Ex.Order 26.4B1 %	Room Air
5/30/2023 01:58	Ex.Order 26.4B1 %	Room Air
5/29/2023 13:26	Ex.Order 26.4B1 %	Room Air
5/29/2023 00:16	Ex.Order 26.4B1 %	Room Air
5/28/2023 13:57	Ex.Order 26.4B1 %	Room Air
5/26/2023 12:45	Ex.Order 26.4B1 %	Room Air
5/25/2023 20:08	Ex.Order 26.4B1 %	Room Air
5/25/2023 13:19	Ex.Order 26.4B1 %	Room Air
5/24/2023 22:26	Ex.Order 26.4B1 %	Room Air
5/24/2023 13:13	Ex.Order 26.4B1 %	Room Air
5/23/2023 01:09	Ex.Order 26.4B1 %	EX Order 26.4B1
5/22/2023 17:28	Ex.Order 26.4B1 %	Room Air

On 07/20/23 at 11:50 AM, the surveyor interviewed the Director of Nursing (DON) regarding Resident #74 EX Order 26.4B1 and requested Resident #74 EX Order 26.4B1 for

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F 695	Continued From page 18 the months of June and July 2023. On 07/20/23 at 12:17 PM, the DON approached the surveyor and said, "Let me tell you, [redacted] were not done. They fell off when we stopped doing every shift vital signs for covid". The surveyor asked if they should have been done and the DON said, "Yes". On 07/27/23 at 09:30 AM, the surveyor reviewed the facility's policy titled, "Oxygen Tubing and Respiratory Products". The policy had a reviewed date of 01/01/23. The policy read that the facility was to ensure all oxygen tubing is single use for residents, clean, properly stored, and dated to prevent the transmission of infection. Under the procedure section, it stated the facility was to ensure if oxygen tubing is not in use, that it is in an oxygen bag labeled with the resident's name and room number as well as the date it was changed. NJAC 8:39-27.1 (a)	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		8/30/23

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F 761	Continued From page 19 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to a.) properly store medications, b.) maintain clean and sanitary medication storage areas, and c.) properly label opened multidose medications. This deficient practice was observed in 3 of 4 medication carts and was evidenced by the following: On 7/20/23 at 12:25 PM, in the presence of Licensed Practical Nurse 1 (LPN1), the surveyor observed the "SMART" nursing unit's medication cart #1. The surveyor and LPN1 observed a total of three (3) loose pills of varying colors and sizes in the bottom of the cart drawer, not in the pharmacy packaging ("bingo" cards). The LPN confirmed that pills should not be loose in the drawer. On 7/20/23 at 12:45 PM, in the presence of Licensed Practical Nurse 2 (LPN2), the surveyor	F 761	F761 SS=D Label/Store Drugs and Biologicals 1. Residents affected by deficient practice: Facility failed to a) properly store medications b) maintain clean and sanitary medication storage areas c) properly label opened multidose medications. There were no residents that were affected by this deficient practice. The loose pills in question were immediately disposed of as per facility policy. Unlabeled multidose bottle of lubricating eye drops was immediately discarded. The locked controlled substance/narcotic medication box was immediately fastened to the drawer in which it was kept. 2. Identify those individuals who could be affected by the deficient practice All residents have the potential to be affected by this deficient practice. All	

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F 761	Continued From page 20 observed the "EX Order 26.4B1" nursing unit's medication cart #1. The surveyor and LPN2 observed a total of ten (10) loose pills of varying colors and sizes in the bottom of the cart drawer, not in the pharmacy packaging. The surveyor further observed the locked controlled substance/narcotic medication box was missing all fasteners or bolts which kept the box secure to the drawer in which it was kept, which would allow the narcotic box to be able to be maneuvered out of the drawer. The surveyor observed one (1) multi-use bottle of prescribed lubricating eye drops, which was confirmed by LPN2 to have been opened and used. The bottle was not labeled or dated with the resident's name or date opened. At this time, LPN2 confirmed that the bottle should be labeled and dated. The LPN further confirmed that pills should not be loose in the drawer, and stated, "I switched cards from one drawer to another and they smashed out. It happens." On 7/21/23 at 10:28 AM, in the presence of Licensed Practical Nurse 3 (LPN3), the surveyor observed the "EX Order 26.4B1" nursing unit's medication cart #2. The surveyor and LPN3 observed one (1) loose pill in the bottom of the cart drawer, not in the pharmacy packaging. On 7/21/23 at 12:00 PM, the surveyor interviewed the Director of Nursing (DON) who stated loose pills should be removed from the carts, and nurses, unit managers, and the pharmacy consultant are responsible for checking the carts for cleanliness and loose pills. The DON further stated that multi-use containers are usually labeled with a small label from the pharmacy with resident information.	F 761	medication carts were checked for loose pills that were discarded immediately as necessary. All locked controlled substance/narcotic medication boxes were checked in all medication carts to ensure that they were secured to the drawers. All multidose bottles of eye drops were checked to make sure that they were labeled properly. None of the residents were affected by this deficient practice. 3. What corrective actions will be accomplished for those residents affected by the deficient practice: " The nurse educator in-serviced licensed nursing staff on the facility policy regarding proper medication storage, medication labeling, disposal of loose pills and unlabeled medications. " The nurse educator in-serviced licensed nursing staff on the steps that should be taken if locked controlled substance/narcotic medication boxes noted to be loose in the drawers. " All medication carts were checked for loose pills that were discarded immediately as necessary. " All locked controlled substance/narcotic medication boxes were checked in all medication carts to ensure that they were secured to the drawers. " All multidose eye drop bottles were checked to make sure that they were labeled properly. " The cleaning schedule of the medication carts was reviewed with the director of housekeeping services and	

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F 761	Continued From page 21 On 7/26/23 at 11:10 AM, the DON informed the surveyor that she spoke with LPN2 who informed her that she believed the label may have come off the eye drop bottle, and the DON's "expectation is if the nurse noticed the bottle not labeled, she would throw it out and ask the pharmacy to have a new one delivered." A review of the facility's "Medication Storage" policy with a revised date 4/2023 included "C. medications will be stored in an orderly, organized manner in a clean area ... E. medications will be stored in the original, labeled containers received from the pharmacy ... F. expired, discontinued and/or contaminated medications will be removed from the medication storage areas and disposed of in accordance with facility policy ..." A review of the facility's "Schedule II Controlled Substance Medication" policy with a revised date 4/2023 under the section titled "Storage of controlled dangerous substances (CDS)" included "1. All CDS medications will be stored under double lock, separate from all other medications. 2. The keys to locked areas that store CDS medications must always be in the possession of a licensed nurse that meets the criteria for handling CDS medications as per facility policy and procedure." A review of the facility's "Medication Labeling Policy and Procedure" revised date of 7/2023, included " ...external medications dispensed in a plastic bag (insulin pens, creams, ointments, etc.) will display a label on the plastic bag and a smaller flag label on the medication directly ... If	F 761	revised as appropriate. " The monthly medication cart check audit tool was reviewed with the pharmacy consultant and updated to include checking for loose pills in medication carts, checking for securement of locked controlled substance/narcotic medication boxes, and proper labeling of multidose eye drops bottles. 4. Measures or systemic changes to ensure that the deficiencies will not recur: " The unit manager/designee will check medication carts for loose pills, securements of controlled substance/narcotic box and proper labeling of multidose bottles of eye drops daily x7, then weekly x4, then monthly x 3 and then quarterly x 2 quarter. " The pharmacy consultant will check medication carts for loose pills, securements of controlled substance/narcotic box and proper labeling of multidose bottles of eye drops monthly. The pharmacy consultant will report findings in the quarterly QAPI meetings. " The DON / designee will review the monthly audits done by the unit manager/designees and a pharmacy consultant. All findings will be reviewed in the quarterly QAPI meetings with QA team for additional recommendations and follow up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315312	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON RIDGE HEALTHCARE AND REHABILITATION	**94 STEVENS ROAD TOMS RIVER, NJ 08755**

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F 761	Continued From page 22 for some reason the label on a medication falls off and is lost the facility must notify the pharmacy of the occurrence immediately. The pharmacy will then resend the medication ..." N.J.A.C. 8:39-29.4	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061535	A. BUILDING: _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON RIDGE HEALTHCARE AND REHABI	94 STEVENS ROAD TOMS RIVER, NJ 08755

(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 NJ00155808, NJ00153438, NJ00155462, NJ00156332 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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: Based on interview and review of other facility documents, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shift as mandated by the State of New Jersey for 1.) The week of 01/23/2022 to 01/29/2022, 2.) The week of 05/08/2022 to 05/14/2022, 3.) The weeks of 06/21/2022 to 07/02/2022, and 4.) The week of 07/03/2022 to 07/09/2022 Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	S560 I. Corrective action(s)accomplished for resident(s)affected: " No residents were identified II. Residents identified having the potential to be affected and corrective action taken: " The deficient practice has the potential to affect all residents residing in the facility.	8/30/23

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

Electronically Signed — 08/06/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HAMPTON RIDGE HEALTHCARE AND REHABI	94 STEVENS ROAD TOMS RIVER, NJ 08755

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S 560	Continued From page 1 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 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) 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 (1) 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. 1. For the week of Complaint staffing from 01/23/2022 to 01/29/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -01/23/22 had 14 CNAs for 164 residents on the day shift, required 20 CNAs. -01/24/22 had 17 CNAs for 164 residents on the day shift, required 20 CNAs. -01/25/22 had 19 CNAs for 163 residents on the day shift, required 20 CNAs. -01/26/22 had 19 CNAs for 163 residents on the day shift, required 20 CNAs. -01/27/22 had 17 CNAs for 163 residents on the day shift, required 20 CNAs. -01/28/22 had 18 CNAs for 163 residents on the	S 560	III. Measures have been put into place to ensure the deficient practice will not recur: " Daily bonuses are offered for double shifts, extra shifts, weekend shifts and staff recognition as needed. " Referral and sign on bonuses are offered. " The call out Policy has been reviewed and the staff has been re-educated " Advertisements signs are placed in front of the building. " The facility is recruiting on multiple employment search engines and multiple social media platforms. " Depending on the needs of the day Nursing management to include DON, Mangers, Supervisors and ADON will be evaluated to assist with resident care. " Competitive rates have been implemented for CNAs. " The facility has multiple contracts with staffing agencies to assist with staffing needs. " The facility has implemented a multifaceted approach for recruitment and retention of employees such as job fairs, flexible scheduling, split shifts, partnership with schools, variety of employee retention related activities, campaign to rehire staff that had resigned, text message campaigns. " The facility utilizes corporate recruiter to assist with advertising and recruitment needs. IV. Corrective actions will be monitored to ensure the deficient practice will not recur: " The DON/Staffing coordinator and administrator will meet daily during the	

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S 560	Continued From page 2 day shift, required 20 CNAs. -01/29/22 had 16 CNAs for 163 residents on the day shift, required 20 CNAs. 2. For the week of Complaint staffing from 05/08/2022 to 05/14/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -05/08/22 had 13 CNAs for 154 residents on the day shift, required 19 CNAs. -05/09/22 had 15 CNAs for 154 residents on the day shift, required 19 CNAs. -05/10/22 had 17 CNAs for 154 residents on the day shift, required 19 CNAs. -05/11/22 had 16 CNAs for 154 residents on the day shift, required 19 CNAs. -05/12/22 had 18 CNAs for 160 residents on the day shift, required 20 CNAs. -05/13/22 had 15 CNAs for 160 residents on the day shift, required 20 CNAs. -05/14/22 had 15 CNAs for 160 residents on the day shift, required 20 CNAs. 3. For the weeks of Complaint staffing from 06/12/2022 to 07/02/2022, the facility was deficient in CNA staffing for residents on 21 of 21 day shifts as follows: The facility was deficient in CNA staffing for residents on 21 of 21 day shifts as follows: -06/12/22 had 15 CNAs for 166 residents on the day shift, required 21 CNAs. -06/13/22 had 16 CNAs for 166 residents on the day shift, required 21 CNAs. -06/14/22 had 20 CNAs for 166 residents on the day shift, required 21 CNAs. -06/15/22 had 18 CNAs for 166 residents on the day shift, required 21 CNAs. -06/16/22 had 17 CNAs for 166 residents on the day shift, required 21 CNAs.	S 560	week to review recruitment effort, staffing for the next day and staffing for the upcoming week. " The DON/Designee will conduct weekly C.N.A. staffing schedule audits to identify trends. " The administrator/designee will review the minutes from resident council to determine whether any concerns regarding care and services are identified monthly for 2 months and then quarterly. " The results of Resident Council meeting minutes as well as identified staffing trends and recruitment data will be reviewed by administrator or designee at the quarterly QAPI meeting. we will audit and monitor this until we are 100% compliance with the state staffing ratio's for 2 months and then one random day per week to check the staffing ratios to make sure we are in compliance with state staffing ratio's. Results of these audits will be brought to QAPI quarterly for this whole year even if we are in 100% compliance.	

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HAMPTON RIDGE HEALTHCARE AND REHABI	94 STEVENS ROAD TOMS RIVER, NJ 08755

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S 560	Continued From page 3 -06/17/22 had 17 CNAs for 168 residents on the day shift, required 21 CNAs. -06/18/22 had 14 CNAs for 168 residents on the day shift, required 21 CNAs. -06/19/22 had 13 CNAs for 168 residents on the day shift, required 21 CNAs. -06/20/22 had 16 CNAs for 170 residents on the day shift, required 21 CNAs. -06/21/22 had 15 CNAs for 170 residents on the day shift, required 21 CNAs. -06/22/22 had 18 CNAs for 170 residents on the day shift, required 21 CNAs. -06/23/22 had 17 CNAs for 170 residents on the day shift, required 21 CNAs. -06/24/22 had 20 CNAs for 173 residents on the day shift, required 21 CNAs. -06/25/22 had 13 CNAs for 173 residents on the day shift, required 22 CNAs. -06/26/22 had 14 CNAs for 173 residents on the day shift, required 22 CNAs. -06/27/22 had 15 CNAs for 173 residents on the day shift, required 22 CNAs. -06/28/22 had 19 CNAs for 173 residents on the day shift, required 22 CNAs. -06/29/22 had 17 CNAs for 173 residents on the day shift, required 22 CNAs. -06/30/22 had 18 CNAs for 173 residents on the day shift, required 22 CNAs. -07/01/22 had 21 CNAs for 173 residents on the day shift, required 22 CNAs. -07/02/22 had 12 CNAs for 173 residents on the day shift, required 22 CNAs. 4. For the week of Complaint staffing from 07/03/2022 to 07/09/2022, 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
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S 560	Continued From page 4 deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -07/03/22 had 13 CNAs for 173 residents on the day shift, required 22 CNAs. -07/04/22 had 17 CNAs for 172 residents on the day shift, required 21 CNAs. -07/05/22 had 18 CNAs for 170 residents on the day shift, required 21 CNAs. -07/06/22 had 19 CNAs for 170 residents on the day shift, required 21 CNAs. -07/07/22 had 19 CNAs for 170 residents on the day shift, required 21 CNAs. -07/08/22 had 15 CNAs for 170 residents on the day shift, required 21 CNAs. -07/09/22 had 14 CNAs for 178 residents on the day shift, required 22 CNAs For the weeks of 07/02/2023 to 07/15/2023 and 07/27/2023 for the survey the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -07/02/23 had 14 CNAs for 168 residents on the day shift, required 21 CNAs. -07/03/23 had 14 CNAs for 168 residents on the day shift, required 21 CNAs. -07/04/23 had 18 CNAs for 168 residents on the day shift, required 21 CNAs. -07/05/23 had 14 CNAs for 167 residents on the day shift, required 21 CNAs. -07/06/23 had 18 CNAs for 167 residents on the day shift, required 21 CNAs. -07/07/23 had 16 CNAs for 167 residents on the day shift, required 21 CNAs. -07/08/23 had 14 CNAs for 167 residents on the day shift, required 21 CNAs. -07/09/23 had 16 CNAs for 167 residents on the day shift, required 21 CNAs. -07/10/23 had 12 CNAs for 167 residents	S 560		

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S 560	Continued From page 5 on the day shift, required 21 CNAs. -07/11/23 had 13 CNAs for 163 residents on the day shift, required 20 CNAs. -07/12/23 had 16 CNAs for 163 residents on the day shift, required 20 CNAs. -07/13/23 had 16 CNAs for 163 residents on the day shift, required 20 CNAs. -07/14/23 had 18 CNAs for 163 residents on the day shift, required 20 CNAs. -07/15/23 had 13 CNAs for 167 residents on the day shift, required 21 CNAs. When interviewed by the surveyor on 07/21/23 at 12:17 PM, the staffing coordinator stated the facility tries its best to follow the staffing guidelines. When interviewed by the surveyor on 7/24/23 at 10:54 AM, the Director of Nursing stated "We are trying our best to follow the ratios. On 07/27/23 at 10:00 AM, the surveyor reviewed the facility provided policy for staffing that was reviewed on 5/2023. The policy reflects that it is the policy to provide adequate staffing to meet the needed care and services for our resident population. It also reflects the following ratios one certified nurse aid to every eight residents for the day shift.	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
315312 Y1	A. Building B. Wing Y2	8/31/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON RIDGE HEALTHCARE AND REHABILITATION	94 STEVENS ROAD TOMS RIVER, NJ 08755

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 F0641	Correction	ID Prefix F0656	Correction	ID Prefix F0688	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.25(c)(1)-(3)	Completed
LSC	08/30/2023	LSC	08/30/2023	LSC	08/30/2023
ID Prefix F0695	Correction	ID Prefix F0761	Correction	ID Prefix	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. #	Completed
LSC	08/30/2023	LSC	08/30/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
7/27/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
061535	A. Building B. Wing	8/31/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON RIDGE HEALTHCARE AND REHABILITATION	94 STEVENS ROAD TOMS RIVER, NJ 08755

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 08/30/2023	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	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/27/2023	☐ 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
	315312	A. BUILDING **01** B. WING _____	C **07/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON RIDGE HEALTHCARE AND REHABILITATION	**94 STEVENS ROAD** **TOMS RIVER, NJ 08755**

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K 000	INITIAL COMMENTS The nursing home building construction was stated to be 1990s with no current major renovations or noted additions. It is a one story building Type V (111) protected construction and is fully sprinklered. The 100 KW exterior diesel generator does 80 % of the facility. The facility has piped in medical gas. The building is connected to the Children's Hospital and has a vacant daycare wing recently unoccupied. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life. The facility has 13 smoke zones. The facility has 204 certified beds. At the time of the survey, the census was 167. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by:	K 271		8/30/23

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

Electronically Signed | 08/07/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315312	A. BUILDING **01** B. WING _____	C **07/27/2023**

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HAMPTON RIDGE HEALTHCARE AND REHABILITATION	**94 STEVENS ROAD** **TOMS RIVER, NJ 08755**

(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
K 271	Continued From page 1 Based on observation and interview on 7/17/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to provide and maintain a level walking surface, free of all obstructions or impediments to full instant use in the case of fire or other emergency in accordance with NFPA 101, 2012 Edition, Section 19.2, 19.2.1, 19.2.7, 7.7, 7.7.1, 7.7.3.2, 7.1.6, 7.1.6.2, 7.1.6.3, 7.1.10, 7.1.10.1. This deficient condition was evidenced for 1 of 7 observed exit discharges by the following findings: On 7/17/23 at 12:18 PM, the surveyor MD and RPOD observed outside the Smart unit by resident rooms EX Order 26.4B that the exit/egress leading to the public way, was observed to have a concrete pad approximately 4' after the discharge leading to the path to the public way. The connection to the concrete path was lifted approximately 1" x 4' wide, leading to the public way, failing to provide a firm level walking surface, free of all obstructions or impediments to full instant use in the case of fire or other emergency. The RPOD stated and confirmed that the area failed to provide a level walking/travel surface to the public way. The exit/egress route was confirmed on the facility evacuation route provided by the MD. The Administrator and RPOD, were informed of the finding at the Life Safety Code exit conference on 7/18/23.	K 271	1. All residents have the potential to be effected by this deficient practice of the concrete pad being lifted at the entrance of the ambulance entrance of the SMART unit, and not connected properly to the pad in front of it causing it not to be level and failing to provide a firm level walking surface. The director of maint on 8/4 /23 purchased concreate and filled the pad to the proper level which created a safe firm level walking surface 2.. All of the concrete pad at all exits leading to public way were checked to make sure they are level and safe . 3.. Added to the monthly environmental rounds sheet that the Director of Maintenance / designee does was an audit of all concrete pads by all exits and means of egress to make sure they are connected properly and level. 4.. The Maintenance director or designee will report all these findings to the QAPI team quarterly . A 100% compliance is expected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315312	A. BUILDING **01** B. WING _____	C **07/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON RIDGE HEALTHCARE AND REHABILITATION	**94 STEVENS ROAD** **TOMS RIVER, NJ 08755**

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K 271	Continued From page 2 NJAC 8:39-31.2(e) NFPA 101:2012 - 7.7, 19.2.7	K 271		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interviews conducted on 7/17/23 in the presence of facility Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice affected 1 of 5 occupied access areas observed and was evidenced by the following: At 12:08 PM, the surveyor in the presence of the MD and RPOD observed in the resident occupied EX Order 26.4B1 room by resident room [redacted], that 2-wall switches shut-off all 6- light fixtures. The area was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. The MD and RPOD both confirmed the finding's at the time of observations.	K 281	1. As all residents have the potential to be effected by this deficient practice of the EX Order 26.4B1 day room not having some lighting on a separate switch which will always stay on and have some illumination at the means of egress in that unit. , . 2. All units and day rooms were checked to see if there is some lights that remain on all the time and not controlled by a switch where they can be shut off causing no illumination at the means of egress. 3. Added to the monthly environmental rounds sheet that the Director of Maintenance / designee does was an audit of all units and all means of egress to make sure there is always lighting that remain on all the time and not controlled by a switch which can cause it to be shut which will mean there won□t be suffice lighting at all means of egress at all times. 4. The Maintenance director or designee will report all these findings to	8/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315312	A. BUILDING **01** B. WING _____	C **07/27/2023**

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K 281	Continued From page 3 The Administrator and RPOD were informed of these findings at the Life Safety Code survey exit conference on 7/18/23. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281	the QAPI team quarterly . A 100% compliance is expected.	

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
315312 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	8/31/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON RIDGE HEALTHCARE AND REHABILITATION	94 STEVENS ROAD TOMS RIVER, NJ 08755

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 Reg. # NFPA 101 LSC K0271	Correction Completed 08/30/2023	ID Prefix Reg. # NFPA 101 LSC K0281	Correction Completed 08/30/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
7/27/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO