STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315364	A. BUILDING _____ B. WING _____	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE CENTER	3 INDUSTRIAL WAY EAST EATONTOWN, NJ 07724

(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 Survey Date: 2/28/23 Census:141 Sample: 28 + 3 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		4/3/23

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

Electronically Signed | 03/13/2023

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F 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that a resident dependent on staff for care, including transferring to bed, received the services needed in a timely and dignified manner. This deficient practice was identified for 1 of 28 residents (Resident #129) reviewed for care and services and was evidenced by the following: On 2/14/23 at 11:10 AM, the surveyor observed Resident #129 in their room sitting in a wheelchair with a family member visiting. The	F 550	1.How will corrective action be accomplished for those individuals□ residents cited for this deficiency? Resident #129 call bell was answered by the primary nurse once the surveyor approached the nurses station to let the nurses know the call light was on, this occurred on *Ex Order 26. 4B1* . Resident #129 was assisted and returned to bed, there was no harm to the resident. 2.How will we identify other resident who have potential to be affected by the same	

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F 550	Continued From page 2 resident stated they just returned from the rehabilitation gym and wanted to return to bed. The surveyor asked the resident how they communicated that with staff, and the resident responded you push the call bell, but it took staff a long time to answer the call bell. When asked how long a long time was, the resident stated it could take thirty minutes to even an hour for staff to come in. On 2/14/23 at 11:15 AM, the surveyor asked the resident to push the call bell and the resident did. The following occurred between 11:15 AM and 11:35 AM: At 11:15 AM, the resident pushed the call bell, and the surveyor went to the hallway to confirm the light outside the resident's room was lit. At 11:25 AM, the surveyor observed the Licensed Practical Nurse (LPN #1) in the hallway walk past the resident's room towards the exit doors to the outside. LPN #1 turned her head and looked into the resident's room as she continued to walk by. At this time, the surveyor checked the light in the hallway outside the resident's room and noticed the light was still lit. A few minutes later, LPN #1 walked past the resident's room in the direction towards the Nurse's Station and looked into the room, but did not stop. At this time, the surveyor checked the light in the hallway outside the resident's room and noticed the light was lit. At 11:30 AM, the resident stated they wanted to return to bed. The family member informed the resident that the surveyor wanted to see how long it would take for staff to answer the light. The resident stated this happened all the time. At this time, the resident's unsampled roommate informed the surveyor that staff did not answer	F 550	deficient Practice? All residents have the potential to be affected by this deficient practice. 3.What measure will be put in place or systemic changes made to ensure that the deficient practice does not recur? Nurse Practice Educator immediately initiated reeducation to all center staff on the importance of answering call bells and the facility call bell policy and procedure. Unit Managers or Designee will conduct two random call bell audits per unit, on each shift, two times a week for three months. Director of Nursing or Designee will attend the resident council meetings monthly for three months to ask the residents about call bell response time satisfaction. 4.How will we monitor our Corrective action to ensure that the deficient practice is being corrected and not recur? Unit Managers or Designee will bring the call bell audits to the monthly QAPI meeting and report the data collected for the next three months to ensure compliance. Director of Nursing or Designee will provide resident feedback from Monthly Resident Council Meetings at monthly QAPI Meetings for three months to ensure	

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F 550	Continued From page 3 the call bell in a reasonable amount of time; it had taken two hours before staff came into the room. At 11:32 AM, the surveyor observed Certified Nursing Aide (CNA #1) in the hallway walk past the resident's room towards the exit doors to the outside and proceeded into another resident's room. CNA #1 turned her head and looked into the resident's room as she continued to walk by. At this time, the surveyor checked the light in the hallway outside the resident's room and noticed the light was still lit. At 11:33 AM, the resident stated they wanted to be transferred into bed. At 11:35 AM, the surveyor observed the resident becoming increasingly aggravated and instructed the family member to transfer them into bed. The family member informed the resident he/she could not transfer them back into bed. The resident then instructed the family member to go to the Nurse's Station to inform the nurse. The family member stated that the surveyor wanted to see how long it would take staff to answer the call bell. At this time, the surveyor informed the resident they would go to the Nurse's Station for the nurse. On 2/14/23 at 11:35 AM, the surveyor arrived at the Nurse's Station and observed four staff members; Registered Nurse (RN), LPN #1, LPN #2, and a Nursing Student, sitting at the Nurse's Station with LPN #1 standing in the hallway in front of the Nurse's Station at their medication cart. The surveyor asked the staff how they knew if a call bell was going off? The RN responded and pointed to a call bell system located on the desk directly next to her that was flashing a red light. There was no sound heard coming from the system only a visual light. The system also displayed Resident #129's room which indicated	F 550	satisfaction of resident call bell response time.	

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F 550	Continued From page 4	F 550		

the call bell had been activated for twenty minutes. The surveyor questioned the twenty minutes to the RN who did not respond. The surveyor then asked the RN who could answer a call bell, and the RN responded usually the CNA was in the hallway and answered the call bell. The RN then stood up and proceeded to walk away from the surveyor. The surveyor followed the RN and asked again who could answer a call bell, and the RN responded anyone.

On 2/14/23 at 11:36 AM, the surveyor observed LPN #1, the resident's assigned nurse go into Resident #129's room.

On 2/14/23 at 11:59 AM, the surveyor observed the call bell system at the Nurse's Station activated with a red light blinking and now a loud beeping sound was coming from the system.

The surveyor reviewed the medical record for Resident #129.

A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in Ex Order 26. 4B1 with diagnoses which included Ex Order 26. 4B1 [redacted].

A review of the admission Minimum Data Set (MDS), an assessment tool dated Ex Order 26. 4B1, reflected the resident had a Ex Order 26. 4B1 [redacted] score of Ex Order 26. 4B1 out of 15, which indicated a Ex Order 26. 4B1. A further review in "Section Ex Order 26. 4B1 Function Status" revealed the resident required Ex Order 26. 4B1

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F 550	Continued From page 5 Ex Order 26. 4B1 of a one-person physical assist to transfer between surfaces including to or from: bed, chair, wheelchair, standing position. On 2/17/23 at 8:43 AM, the Director of Nursing (DON) provided the surveyor with a copy of the facility's "Call Lights" policy. The DON stated that call bells should be answered by staff within three to five minutes, and any staff member could answer a call bell. The DON stated that occasionally she completed call bell audits, but was not something she had completed lately since the topic had not recently come up at Resident Council meetings. The surveyor at this time requested from the DON if the system could print a call bell log, and the DON stated she was unsure, but she would check. On 2/23/23 at 1:38 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) and the DON of the above observation and asked the facility to provide any additional information tomorrow. On 2/24/23 at 11:27 AM, the DON in the presence of the LNHA and survey team acknowledged the above observation was unacceptable; that all staff could answer a call bell. At this time, the LNHA stated that the facility's expectation was anyone can walk into a room and answer a call bell; anyone who walks by an activated call bell should answer a call bell. If the staff member was not a licensed professional and what the resident was requesting was beyond their scope; then they should grab a nurse or a CNA for assistance. The LNHA continued that best practice would be a call bell should be answered within five minutes. The LNHA also stated their call bell system did	F 550		

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F 550	Continued From page 6 not generate reports of call bell wait times that they could provide to the surveyor. A review of the facility's "Call Lights" policy dated reviewed 2/1/23, included...all patients will have a call light or alternative communication device within their reach at all times when unattended. Staff will respond to call lights and communication devices promptly.... A review of the facility provided undated "Call Light Response - Best Practices" policy included no one -including managers, directors, the [LNHA], the [DON], you or me - should ever walk by a call light...answering call lights for all residents/patients is everyone's responsibility, regardless of assignments...answering a call bell right away reduces resident/patient anxiety and decreases the frequency of calling. Answer right away, even if it's to say that help will be there in ten minutes... A review of the facility's "Resident Rights Under Federal Law" policy dated revised 2/1/23, included patients/residents have the fundamental right to considerate care that safeguards their personal dignity along with respecting cultural, social, and spiritual values...purpose: to treat each resident with respect and dignity and care for each resident in an environment that promotes maintenance or enhancement of his/her self-esteem and self-worth...to incorporate the resident's goals, preferences, and choices into care... NJAC 8:39-4.1(a)(12); 27.1(a)	F 550		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609		4/3/23

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F 609	Continued From page 7 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, the facility failed to implement their abuse policy by reporting to the New Jersey Department of Health (NJDOH) an injury of unknown origin that was discovered on [redacted]. This deficient practice was identified for 1 of 3 residents (Resident #36) reviewed for abuse and was evidenced by the	F 609	1.How will corrective action be accomplished for those individuals' residents cited for this deficiency? Resident #36 [redacted] on Ex Order 26. 4B1 [redacted] was reported to the Department of Health and the Ombudsman by the Director of Nursing on Ex Order 26. 4B1 .	

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F 609	Continued From page 8 following: On 2/14/23 at 11:16 AM, the surveyor observed Resident #36 in the dayroom in a wheelchair participating in group activities with other residents at a table. The resident's wheelchair seat was equipped with a Ex Order 26. 4B1 [redacted]. The surveyor reviewed the medical record for Resident #36. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility in Ex Order 26. 4B1 with diagnoses which included Ex Order 26. 4B1 [redacted]. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated Ex Order 26. 4B1, reflected the resident had a [redacted] score of [redacted] out of 15, which indicated a Ex Order 26. 4B1 [redacted]. Further review revealed the resident required limited assistance from staff for Ex Order 26. 4B1 [redacted] and that the resident had one NJ Exec. Order 26:4.b.1 since admission or prior assessment. On 2/16/23 at approximately 2:00 PM, the surveyor requested from the Director of Nursing (DON) any incidents, accidents, grievances or investigations for Resident #36. On 2/17/23 at 8:15 AM, the DON provided the surveyor two incident reports for Resident #36 which both occurred on Ex Order 26. 4B1; one at 3:30 AM	F 609	2.How will we identify other resident who have potential to be affected by the same deficient Practice? All residents have the potential to be affected by this deficient practice. 3.What measure will be put in place or systemic changes made to ensure that the deficient practice does not recur? Administrator, Director of Nursing and Assistant Director of Nursing were reeducated on March 13, 2023 on mandatory reporting requirements for incidents and accidents involving allegations of abuse, neglect, exploitation, mistreatment, misappropriation and injuries of unknown source by regional nurse consultant. All center staff will be reeducated by Nurse Practice Educator or designee on mandatory reporting requirements to include injuries of unknown origin. The Director of Nursing or Designee will audit monthly all reportable incidents and accidents for three months to ensure all appropriate agencies were contacted within the required time frames per regulation. 4.How will we monitor our Corrective action to ensure that the deficient practice is being corrected and not recur? The Director of Nursing or Designee will	

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F 609	Continued From page 9 and the other at 6:00 PM. A review of the incident report dated [redacted] at 3:30 AM, included the resident had an unwitnessed [redacted] on [redacted] at 3:30 AM, that the resident was found lying on the floor next to their bed. The resident was assessed for injury with [redacted] found; [redacted] were initiated; both physician and family were notified. A review of the incident report dated [redacted] at 9:00 PM, included the nurse observed the resident in bed resting with a [redacted] found in the [redacted] with no other injuries found during a [redacted] assessment. The resident informed the nurses he/she hit their [redacted] on the nightstand, however on the previous 11:00 PM to 7:00 AM shift, the resident had a [redacted] observed during a [redacted] assessment. The site was cleaned with normal saline solution and pressure was applied; [redacted] checks initiated; resident sent to the [redacted] per Physician; and family notified. The resident at the [redacted] received a [redacted] which found [redacted]. The resident received [redacted]. A review of the Interdisciplinary Care Team (IDCP) Note indicated that the nurse found the resident in bed with [redacted] on their sheets. The team believed the incident might have occurred as resident informed the nurse he/she hit their [redacted] on the nightstand and unlikely from [redacted] the previous	F 609	bring all reportable events to the monthly QAPI meeting for three months and review them to ensure compliance.	

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F 609	Continued From page 10 night. The IDCP team ruled out abuse and neglect and responded immediately. On 2/17/23 at 1:26 PM, the surveyor asked the DON if she provided all the documents for the incident that occurred on [redacted] at 9:00 PM, and the DON responded, "I gave you everything". The DON continued that the resident had [redacted], NJ Exec. Order 26:4.b.1 of unknown origin. The incident that occurred with [redacted] of unknown origin had documented that the resident told his/her primary nurse that he/she hit their [redacted] on the nightstand. The surveyor asked if the resident was alert and oriented to person, place, and time, and the DON responded that the resident had Ex Order 26. 4B1 but could make wants known. The DON stated she felt the resident's statement that they hit their [redacted] on the nightstand was accurate. The surveyor asked the DON if she reported the incident on [redacted] at 9:00 PM to the NJDOH, and the DON stated that she only reported the initia[redacted] from [redacted] at 3:30 AM. When asked, the DON acknowledged that she should have reported the incident that occurred on [redacted] at 9:00 PM as well, because she was required to report [redacted] of unknown origin to the NJDOH. On 2/24/23 at 11:27 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA) and survey team acknowledged the incident on [redacted] at 9:00 PM had not been reported at the time of the incident to the NJDOH and should have been. The DON further stated she was the one responsible for reporting to the NJDOH. A review of the facility's "Abuse Prohibition" policy dated revised 10/24/22, included... immediately	F 609		

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F 609	Continued From page 11 upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the Administrator or designee will perform the following: ...report allegations involving abuse (physical, verbal, sexual, mental) not later than two hours after the allegation is made. Report allegations to the appropriate state and local authority(s) involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of patient property not later than two hours after the allegation is made if the event results in serious bodily injury... A review of the facility's "Accidents/Incidents" policy dated revised 10/24/22, included...staff will report, review, and investigate all accidents/incidents which occurred, or allegedly occurred, on or off Center property involving, or allegedly involving, a patient who is receiving services... allegations or suspicions of abuse, mistreatment, neglect, or misappropriation are reported to the DON and/or Administrator immediately to ensure timely reporting within the required time frames... NJAC 8:39-9.4(e)	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse,	F 610		4/3/23

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F 610	Continued From page 12 neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, the facility failed to implement their abuse policy by thoroughly investigating an NJ Exec. Order 26:4.b.1 [redacted] to rule out abuse or neglect for a resident identified on Ex Order 26. 4B1 [redacted]. This deficient practice was identified for 1 of 3 residents (Resident #36) reviewed for abuse and was evidenced by the following: On 2/14/23 at 11:16 AM, the surveyor observed Resident #36 in the dayroom in a wheelchair participating in group activities with other residents at a table. The resident's wheelchair seat was equipped with a Ex Order 26. 4B1 [redacted]. The surveyor reviewed the medical record for Resident #36. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility in Ex Order 26. 4B1 with diagnoses which included Ex Order 26. 4B1 [redacted].	F 610	1.How will corrective action be accomplished for those individuals' residents cited for this deficiency? Resident #36 [redacted] on Ex Order 26. 4B1 [redacted] was reported to the Department of Health and the Ombudsman by the Director of Nursing on Ex Order 26. 4B1 [redacted]. Investigation concluded and abuse/neglect was ruled out. 2.How will we identify other resident who have potential to be affected by the same deficient Practice? All residents have the potential to be affected by this deficient practice. 3.What measure will be put in place or systemic changes made to ensure that the deficient practice does not recur? Nurse Practice Educator or Designee will reeducate all staff to report, review, investigate all accidents/incidents which occurred, or allegedly occurred on or off center property involving a patient	

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	315364	A. BUILDING _____ B. WING _____	02/28/2023

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F 610	Continued From page 13 A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated Ex Order 26. 4B1, reflected the resident had a [redacted] score of [redacted] out of 15, which indicated a Ex Order 26. 4B1 [redacted]. Further review revealed the resident required limited assistance from staff for Ex Order 26. 4B1 [redacted] and that the resident had NJ Exec. Order 26:4.b.1 since admission or prior assessment. On 2/16/23 at approximately 2:00 PM, the surveyor requested from the Director of Nursing (DON) any incidents, accidents, grievances or investigations for Resident #36. On 2/17/23 at 8:15 AM, the DON provided the surveyor two incident reports for Resident #36 which both occurred on Ex Order 26. 4B1; one at 3:30 AM and the other at 6:00 PM. A review of the incident report dated Ex Order 26. 4B1 at 3:30 AM, included the resident had an NJ Exec. Order 26:4.b.1 on Ex Order 26. 4B1 at 3:30 AM, that the resident was found lying on the floor next to the bed. The resident was assessed for injury with NJ Exec. Order 26:4.b.1; Ex Order 26. 4B1 [redacted] were initiated; both physician and family were notified. A review of the incident report dated Ex Order 26. 4B1 at 9:00 PM, included the nurse observed the resident in bed resting with a Ex Order 26. 4B1 [redacted] found in the Ex Order 26. 4B1 [redacted] with NJ Exec. Order 26:4.b.1 found during a Ex Order 26. 4B1	F 610	receiving services. All licensed nurses will report accidents/incidents and assist with a timely investigation. All incidents and accidents will be discussed in clinical meetings to ensure all Interdisciplinary Team Members are aware. Director of Nursing and Nursing Home Administrator will review reportable events and ensure timely reporting and documentation has been completed per federal regulations. Director of Nursing or Designee will audit monthly all reportable events for three months. 4.How will we monitor our Corrective action to ensure that the deficient practice is being corrected and not recur? Director of Nursing or Designee will bring all incident /accident reports and reportable events for the month to the monthly QAPI meeting for three months and review them to ensure compliance.	

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F 610	Continued From page 14 assessment. The resident informed the nurses he/she hit their [Ex Order 26.] on the nightstand, however on the previous 11:00 PM to 7:00 AM shift, the resident had a [NJ Exec. Order 26:4.b.1] observed during a [Ex Order 26. 4B1] assessment. The site was cleaned with normal saline solution and pressure was applied; [Ex Order 26. 4B1] checks initiated; resident sent to the hospital per Physician; and family notified. The resident at the hospital received a [Ex Order 26. 4B1] which found [NJ Exec. Order 26:4.b.1]. The resident received [Ex Order 26. 4B1]. A review of the Interdisciplinary Care Team (IDCP) Note indicated that the resident was found by the nurse in bed with [Ex Order 26. 4] on their sheets. The team believed the incident might have occurred as resident informed the nurse he/she hit their [Ex Order 26.] on the nightstand and unlikely from the fall the previous night. The IDCP team ruled out abuse and neglect and responded immediately. Witness statements included from multiple staff "I don't know" for what happened. There was no evidence the bedside table was observed with [Ex Order 26. 4] on it; when the resident was last seen; when the resident was last toileted; if anyone was observed going into the resident's room; how the resident hit their [Ex Order 26.]; if the resident's roommate was ambulatory or interviewed to rule out abuse or neglect. On 2/17/23 at 9:12 AM, the surveyor observed Resident #36 in his/her room fully dressed sitting on the edge of his/her bed wearing sneakers on his/her feet. The resident said hello and gestured toward his/her tray across the room and stated he/she was about to breakfast. The surveyor asked if the resident had [NJ Exec. Order 26:4.b.] lately and	F 610		

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F 610	Continued From page 15 he/she stated '*Ex Order 26. 4B1* [redacted]'. When asked if he/she had slipped out of his/her wheelchair he/she again stated '*Ex Order 26. 4B1* [redacted]'. Then surveyor observed the resident stand and pivot himself/herself into his/her wheelchair without issue and the surveyor left the room. On 2/17/23 at 1:26 PM, the surveyor asked the DON if she provided all the documents for the incident that occurred on *Ex Order 26. 4B1* at 9:00 PM, and the DON responded, "I gave you everything". The DON continued that the resident had *NJ Exec. O* [redacted] of unknown origin. The incident that occurred with *NJ Exec. Order 26:4.b.1* of unknown origin had documented that the resident told his/her primary nurse that he/she hit their *Ex Order 26.* on the nightstand. The surveyor asked if the resident was alert and oriented to person, place, and time, and the DON responded that the resident had *Ex Order 26. 4B1* [redacted] but could make wants known. The DON stated she felt the resident's statement that they hit their *Ex Order 26.* on the nightstand was accurate. The DON stated the facility's process for investigating *NJ Exec. Order 26:4.b.1* of unknown origin was to interview and get statements from staff that were working when the *NJ Exec. Order 26.* [redacted] was found; review the resident's chart and medications; interview the roommate when possible; and have Social Services interview the resident. At this time, the surveyor reviewed the investigation with the DON who acknowledged this was not done. The DON stated the resident had told their primary nurse he/she had hit their *Ex Order 26.* [redacted] so "I didn't go any further with it". The DON acknowledged the investigation was not complete to rule out abuse or neglect. On 2/24/23 at 11:27 AM, the DON, in the	F 610		

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F 610	Continued From page 16 presence of the Licensed Nursing Home Administrator (LNHA) and survey team acknowledged the incident report was not a complete investigation. A review of the facility's "Accidents/Incidents" policy dated revised 10/24/22, included... staff will report, review, and investigate all accidents/incidents which occurred, or allegedly occurred on or off Center property involving, or allegedly involving a patient receiving services...the licensed nurse will: report accidents/incidents and assist with a timely investigation to determine root cause analysis...any incident that may be considered an allegation of abuse, neglect, misappropriation of patient property, and/or crime against an elderly person is managed in accordance with the "Abuse Prohibition" policy...The DON and Administrator must review the event for completion and lock the event within five days or per "Abuse Prohibition" policy for incidents of abuse...The Administrator, DON, or designee will review all accidents/incidents to determine: accidents/incidents or allegations have been appropriately and timely reported; required documentation has been completed; accident/incident has been investigated...When conducting an investigation, the Administrator, DON, or designee will: make every effort to ascertain the cause of the accident/incident; initiate a timeline chronology; observe environment, assess available documentation and previous accidents/incidents as appropriate (considering recreating the event.); conduct witness interviews from all staff and visitors who may have knowledge of the accident/incident; document the root cause and initiate actions to prevent or reduce recurrence or further	F 610		

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F 610	Continued From page 17 accident/incident; monitor all aspects of the incident and investigation involving patients are documented in the [computer medical program] risk Management portal; complete the investigation within five working days... A review of the facility's "Abuse Prohibition" policy dated revised 10/24/22, included...staff will identify events - such as suspicious bruising of patients, occurrences, patterns, and trends that may constitute abuse - and determine the direction of the investigation...injuries of unknown origin will be investigated to determine if abuse or neglect is suspected... NJAC 8:39-4.1(a)(5), 27.1(a)	F 610		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure[redacted] were implemented and monitored for a resident with [redacted] in the facility. This deficient practice was identified for 1 of 3 residents (Resident #38) reviewed for accidents and was evidenced by the following:	F 689	1.How will corrective action be accomplished for those individuals□ residents cited for this deficiency? Resident #38 was provided with a [redacted] that was working and functioning properly. We received a verbal and written report from the [redacted] that resident #38 had [redacted] of the [redacted]	4/3/23

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F 689	Continued From page 18 On 2/14/23 at 11:08 AM, the surveyor observed Resident #38 sitting in their wheelchair in their room. The surveyor observed the resident stand up from their wheelchair and quickly sit back down when they noticed the surveyor at the door. The surveyor observed what appeared to be a chair alarm placed on the back of the resident's wheelchair, but they did not hear the alarm sound when the resident stood up. The surveyor with permission proceeded into the resident's room to interview them. The resident informed the surveyor that he/she was at the facility for rehabilitation, but they did not know when they were being discharged home. On 2/15/23 at 11:51 AM, the surveyor observed the resident sitting in their wheelchair in their room watching television. The surveyor observed the resident had a chair alarm on the back of their wheelchair that was connected and appeared to be set in the on position. The resident appeared happy and informed the surveyor he/she had no concerns. The surveyor reviewed the medical record for Resident #38. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in *Ex Order 26. 4B1* with diagnoses which included *Ex Order 26. 4B1* [redacted]. A review of the admission Minimum Data Set (MDS), an assessment tool dated [redacted], reflected the resident had a *Ex Order 26. 4B1* [redacted] score of a [redacted] out of 15,	F 689	[redacted]. Resident #38 did receive a physician order for the use of NJ Exec. Order 26:4.b.1 immediately when the surveyor inquired about it, center also received Physician Orders for checking placement and function of the [redacted] every shift. The care plan was updated with interventions [redacted] on *Ex Order 26. 4B1* which did include the NJ Exec. Order 26:4.b.1. 2.How will we identify other resident who have potential to be affected by the same deficient Practice? All residents have the potential to be affected by this deficient practice. 3.What measure will be put in place or systemic changes made to ensure that the deficient practice does not recur? Nurse Practice educator or designee will reeducate all licensed nurses on the policy and procedure for bed/chair alarms specifically ensuring having a physician order and care plan. House wide audit for all residents/patients with a bed/chair alarm was completed on February 15, 2023. Audit included Physician order for use, placement and function and Care Plans were in place. Director of Nursing or Designee will conduct an audit of five random residents weekly with alarms for three months.	

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F 689	Continued From page 19 which indicated an Ex Order 26. 4B1. A further review of "Section [redacted] Health Conditions" reflected the resident had NJ Exec. Order 26:4.b.1 since admission to the facility. A review of the Progress Notes included a General Note dated Ex Order 26. 4B1 at 2:21 PM, that indicated the resident was non-compliant with call bell or requesting assistance; observed on floor sitting up; attempted to use bath on his/her own with NJ Exec. Order 26:4.b.1 noted; redirected to call for help for any needs. On 2/17/23 at 10:00 AM, the surveyor requested from the Director of Nursing (DON) any accidents, incidents, and investigations for Resident #38 since the resident was admitted to the facility. On 2/17/23 at 11:00 AM, the surveyor asked the DON if there were any investigations, and the DON responded the resident had NJ Exec. Order 26:4 at the facility and she was waiting to receive a copy of the Ex Order 26. 4 report from Ex Order 26. 4B1. The DON stated the Ex Order 26. 4 was negative for NJ Exec. Order 26:4.b.1, but the facility never received a copy of the report. On 2/17/23 at 11:40 AM, the surveyor observed the resident sitting in his/her wheelchair in their room removing a bag from their dresser. The resident said hello to the surveyor, but seemed NJ Exec. Order 26:4.b.1 when the surveyor attempted to interview them. The surveyor observed a chair alarm attached to the resident's wheelchair. On 2/17/23 at 11:55 AM, the surveyor reviewed the incident report provided from DON for NJ Exec. Order that occurred on Ex Order 26. 4B1. The report included that the resident was observed sitting on floor in	F 689	4.How will we monitor our Corrective action to ensure that the deficient practice is being corrected and not recur? Nurse Practice Educator or Designee will bring the results of the five weekly chart audits to the monthly QAPI Meeting for three months to present their findings to ensure compliance.	

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F 689	Continued From page 20	F 689		

front of bathroom door inside his/her room; resident described attempting to go to the bathroom, [redacted] went weak and landed on his/her [redacted]. The immediate actions taken were the resident was redirected to use call bell when toileting was needed or any other personal assistance, bed and chair alarm implemented. The interventions included to do [redacted]; pain management as needed; fifteen-minute checks; toilet schedule upon rising after meals and at bedtime; bed and chair alarm.

The surveyor continued to review the resident's medical record.

A review of the Order Summary Report did not include a physician's order (PO) for bed or chair alarms.

A review of the January 2023 and February 2023 Medication Administration Records (MAR) did not include the use, placement, or checking the function of the [redacted].

A review of the January 2023 and February 2023 Treatment Administration Records (TAR) did not include the use, placement, or checking the function of the [redacted].

A review of the individualized person-centered care plan included a focus area initiated [redacted], nine days after the resident's fall on [redacted], that the resident is [redacted] with regards to [redacted] Interventions included to

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F 689	Continued From page 21 keep bed in low position; observe for and report signs and symptoms of nausea and/or vomiting, abdominal distention, decrease in bowel movements, decrease in bowel sounds and abdominal pain; observe for changes in medical status, pain status, mental status and medication side effects that may contribute to cognitive loss, dementia, delirium and can lead to increase fall risk, report to physician as indicated; observe for signs and symptoms of abnormal blood pressure including orthostatic blood pressure and promote self-management strategies; and observe for signs and symptoms of depression and promote self-management strategies. The care plan did not include the resident's NJ Exec. Order 26:4.b.1 on Ex Order 26. 4B1 or the interventions to use NJ Exec. Order 26:4.b.1. On 2/21/23 at 1:28 PM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated the resident suffered from Ex Order 26. 4B1 [redacted]. The LPN stated the resident was only NJ Exec. Order 26:4.b.1, and most of the time he/she NJ Exec. Order 26:4.b.1 what you were saying. The LPN stated for example you could tell the resident not to do something and ten minutes later, he/she would do what you just instructed them not to do. The LPN stated the resident was NJ Exec. Order 26:4.b.1 and had NJ Exec. Order at the facility when he/she attempted to get up without using the call bell for assistance. The LPN stated the resident had a call bell that "you check the function of the alarm daily." The LPN stated the nurse did not document that the alarm was checked daily; it was not on the MAR or TAR to do so. The LPN stated the care plan was completed by the Unit Manager/LPN (UM/LPN). On 2/21/23 at 1:35 PM, the surveyor asked the LPN to review the resident's physician's orders	F 689		

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F 689	Continued From page 22 and verify if there was a PO for the resident's [NJ Exec. Ord] [redacted]. The LPN confirmed there was no PO, but he stated there would be no PO for a NJ Exec. Order 26:4.b.1. On 2/21/23 at 1:51 PM, the surveyor interviewed the UM/LPN who stated if a resident was a high risk for falls or had a fall, the facility would initiate a chair or bed alarm. The UM/LPN acknowledged you would need to obtain an order from the physician for the bed and chair alarm, but it was a nursing intervention and the physician needed to be made aware. The UM/LPN stated there was usually a PO to check once a shift for function and placement. The UM/LPN stated that the alarm was not considered a restraint because the resident could release themselves. The UM/LPN confirmed there was no PO for the bed and chair alarms. The surveyor informed the UM/LPN that they observed the resident stand up from their wheelchair on [Ex Order 26. 4B1], and the surveyor did not hear the alarm sound. The surveyor asked the UM/LPN to accompany them to the resident's room to check the alarm's function. On 2/21/23 at 1:56 PM, the surveyor accompanied by the UM/LPN went to Resident #38's to check the function of the resident's chair alarm. The UM/LPN instructed the resident they were going to check their chair alarm and needed the resident to go into the bathroom with her to use the bathroom wall bar to assist her with positioning the resident to standing. The resident did as instructed, and stood up from the wheelchair using the wall bar in the bathroom. The surveyor and the UM/LPN observed that the chair alarm did not sound as it should. The UM/LPN began to play with the chair alarm, and	F 689		

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F 689	Continued From page 23 the alarm went off. The UM/LPN stated the alarm was turned on, so there must have been a connection issue. After this, the surveyor and UM/LPN left the resident, and the UM/LPN stated that alarm should be checked every shift to ensure functioning properly. The UM/LPN stated that if the Certified Nursing Aide (CNA) noticed the alarm was not functioning properly, they should have notified the nurse, and the nurse should have noticed there was no PO for the [NJ Exec. Order 26:4.b.] [redacted] and called the physician. The UM/LPN stated she updated the resident's care plan yesterday to include the [NJ Exec. Order 26:4.b.1] [redacted] after she reviewed their care plan and noticed it was not included. The UM/LPN confirmed the NJ Exec. Order 26:4.b.1 were an intervention from [NJ Exec. Order 26:4.] on [Ex Order 26. 4B1], and the care plan should have been initiated and updated after [NJ Exec. Order 26:4.] [redacted]. On 2/21/23 at 2:03 PM, the surveyor interviewed the DON who stated bed and chair alarms were an intervention used if the resident had a fall or was a high risk for falls. The DON confirmed you would need a PO for both alarms, and nurses needed to check every shift for the alarms functioning. The DON confirmed you would include bed and chair alarms in a care plan. On 2/22/23 at 1:09 PM, the surveyor re-interviewed the DON who stated bed and chair alarms were located under the facility's restraint policy, but the bed and chair alarm were not considered a restraint for this resident, so the facility did not obtain a consent. The DON stated the alarms were a nursing intervention and the facility needed to obtain a PO.	F 689		

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F 689	Continued From page 24 On 2/23/23 at 8:45 AM, the surveyor asked the DON when the facility assessed residents for the risk of falls? The DON stated residents were assessed upon admission and re-admission, quarterly, or after they had a fall in the facility. At this time, the surveyor requested a copy of the resident's [NJ Exec. Order 26:4] assessment from admission and after [NJ Exec. Order 26:4.b] on [Ex Order 26. 4B1]. On 2/23/23 at 10:06 AM, the DON provided the surveyor with the resident's admission "Nursing Documentation - V 11" dated [NJ Exec. Order 26:4] and a copy of the "eINTERACT Change in Condition Evaluation - V 5.1" dated [Ex Order 26. 4B1]. The DON stated the asterisk on the admission nursing assessment dated [Ex Order 26. 4B1], indicated the resident was at a NJ Exec. Order 26:4.b.1. The Change in Condition assessment dated [Ex Order 26. 4B1] was initiated after [NJ Exec. Orde] on [Ex Order 26. 4B1]. On 2/24/23 at 11:27 AM, the DON in the presence of the Licensed Nursing Home Administration (LNHA) and in the presence of the survey team, acknowledged that the resident did not have a PO for the NJ Exec. Order 26:4.b.1 until surveyor inquiry; the NJ Exec. Order 26:4.b.1 placement and function were not being checked every shift; and the care plan should have been initiated after [NJ Exec. Order 26:] on [Ex Order 26. 4B1], and should have included the NJ Exec. Order 26:4.b.1. A review of the facility's "Falls Management" policy dated revised 6/15/22, included patients will be assessed for risk of falling as part of the nursing assessment process. Interventions to reduce risk and minimize injury will be implemented as appropriate...patients experiencing a fall will receive appropriate care	F 689		

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F 689	Continued From page 25 and post-fall interventions will be implemented...purpose: to identify risk of falls and minimize the risk of recurrence risk of falls; to evaluate the patient for injury post-fall and provide appropriate and timely care; to ensure the patient-centered care plan is reviewed and revised according to patient's fall risk status...implement and document patient-centered interventions according to individual risk factors in the patient's plan of care, adjust and document individualized intervention strategies as patient condition changes... NJAC 8:39-27.1(a)	F 689		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F 692		4/3/23

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F 692	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to obtain weekly weights as ordered for a resident with a significant [redacted] since Ex Order 26. 4B1. This deficient practice was identified for 1 of 4 residents (Resident #30) reviewed for nutrition and was evidenced by the following: On 2/14/23 at 10:55 AM, the surveyor observed Resident #30 in his/her room with the breakfast tray on an over bed table. The surveyor observed on the tray an empty cup of juice and the rest of the tray was untouched. At that time, the Licensed Practical Nurse (LPN) informed the surveyor that Resident #30 eats slowly and requested staff leave the tray at the bedside. The LPN confirmed the resident only drank the juice. The surveyor reviewed the medical record for Resident #30. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in Ex Order 26. 4B1 with diagnoses which included Ex Order 26. 4B1 [redacted]. A review of the most recent annual Minimum Data Set (MDS), an assessment tool dated Ex Order 26. 4B1, reflected the resident had a [redacted] score of [redacted] out of 15, which indicated a Ex Order 26. 4B1 [redacted]. The assessment further indicated the resident had a significant Ex Order 26. 4B1 or more in the last month or a Ex Order 26. 4B1 or more	F 692	1.How will corrective action be accomplished for those individuals' residents cited for this deficiency? For resident #30, we obtained the weight for the resident on Ex Order 26. 4B1 after inquiry from the surveyor. The resident had a Ex Order 26. 4B1 [redacted] and there was no harm to the resident. 2.How will we identify other residents who have potential to be affected by the same deficient Practice? All residents have the potential to be affected by this deficient practice. 3.What measure will be put in place or systemic changes made to ensure that the deficient practice does not recur? All direct care staff will be reeducated by Nurse Practice Educator or designee on facilities weights policy and procedure to include weekly weights as ordered by physician. Unit Managers or Designee will complete audits on five residents on each unit weekly for three months. 4.How will we monitor our Corrective action to ensure that the deficient practice is being corrected and not recur? Unit Managers or Designee will bring their audits to the monthly QAPI Meeting and	

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F 692	Continued From page 27 in the last 6 months and was not on a prescribed Ex Order 26. 4B1 regimen. A review of the Progress Notes included a Nutrition Note dated Ex Order 26. 4B1, which indicated the resident had a significant Ex Order 26. 4B1 in three and six months that was undesirable with a goal of gradual Ex Order 26. 4B1. The plan was to provide a regular advanced diet with double portions of vegetables, breads, starch, eggs, salads, and sides; continue house supplements, fortified vanilla pudding; chocolate chip cookies; and reweigh in two weeks. A review of the Progress Notes included a Nutrition Note dated Ex Order 26. 4B1, to increase house supplement to twice a day and order weekly weights. A review of the Order Summary Report included a physician's order (PO) dated Ex Order 26. 4B1, to weigh every evening shift on Friday for weekly weights. A review of the Weights and Vitals summary reflected the resident weighed the following: Ex Order 26. 4B1 Ex Order 26. 4B1 . (Ex Order 26. 4B1 Ex Order 26. 4B1 . (Ex Order 26. 4B1) Ex Order 26. 4B1 . (Ex Order 26. 4B1 Ex Order 26. 4B1) Ex Order 26. 4B1 . (Ex Order 26. 4B1 since Ex Order 26. 4B1) Ex Order 26. 4B1 . (Ex Order 26. 4B1 since Ex Order 26. 4B1) Ex Order 26. 4B1 . (Ex Order 26. 4B1 since Ex Order 26. 4B1)	F 692	present their data monthly for three months to ensure compliance.	

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Ex Order 26. 4B1 .

There was no evidence the resident was weighed weekly as ordered. There was no weights 12/6/22; 12/23/22; 12/20/22; 1/6/23; 1/13/23; 1/27/23; 2/3/23; 2/10/23; and 2/17/23.

On 2/17/23 at 12:00 PM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) who stated if a resident had a physician's order for weekly weights, then the resident should be weighed weekly. The UM/LPN with the surveyor reviewed Resident #30's Physician Orders Summary (POS) and Medication Administration Record (MAR) which revealed a PO dated *Ex Order 26. 4B1* to weigh the resident on the evening shift every Friday for weekly weights. A review of the corresponding MARs since *Ex Order 26. 4B1*, revealed the weights were not documented. The UM/LPN acknowledged that the weekly weights were not taken, and that the weights should be documented in the resident's medical records. She further stated that she was not aware that the resident had a PO for weekly weights.

On 2/22/23 at 12:33 PM, the surveyor interviewed the Registered Dietitian (RD) who stated that she received weekly weights on Fridays. If there were a PO for a weekly weights, she would run a report from the electronic medical records and if there were missing weights, she would email the Director of Nursing (DON) and would verbally tell the nurses on the unit. The RD stated she was due to see Resident #30 because the resident had a *Ex Order 26. 4B1* of , but it should be around 22. At that time, the surveyor reviewed emails with the RD that were labeled

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F 692	Continued From page 29 weights for Ex Order 26. 4B1 from the RD to the DON which indicated that Resident #30 was included on the list of residents whose weights were missing. On 2/22/23 at 12:23 PM, the surveyor interviewed the DON who stated that there were monthly weight meetings, and they go over any weight issues that the residents might have then. The DON stated we would also go over a list of any residents who were missing weights during morning meetings. She further stated getting the weights done "could be challenging", but she would not express what was challenging. She stated that she would expect the UM/LPN to know the residents who received weekly weights. The facility process was the Certified Nurse Aides (CNA) weighed the residents and the unit managers should make sure that the weights were completed. The surveyor continued to review the resident's medical record. A review of the individualized person-centered care plan included a focus area initiated on Ex Order 26. 4B1, for the resident had a diagnosis of Ex Order 26. 4B1. Interventions included to provide Ex Order 26. 4B1 education and related complications as appropriate and provide Ex Order 26. 4B1 diet, Ex Order 26. 4B1 and chopped meats as ordered. The care plan did not include the resident had significant Ex Order 26. 4B1. On 2/22/23 at 1:55 PM, the surveyor reviewed the resident's care plan with the RD. The RD confirmed the care plan did not include the resident's significant Ex Order 26. 4B1 and	F 692		

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F 692	Continued From page 30 acknowledged it should. On 2/24/23 at 11:27 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA) and survey team confirmed the resident had a PO for weekly weights that was not consistently being followed, and the resident had not been weighed since Ex Order 26. 4B1 until surveyor inquiry, and the resident did not lose any additional Ex Order 26. 4B1 A review of the facility's "Physician/Advanced Practice Provider (APP) Orders" policy dated revised 3/1/22, did not include carrying-out physician's orders as prescribed. A review of the facility's "Weights and Heights" policy dated revised 6/15/22, included patients are weighed upon admission and/or re-admission, then weekly for four weeks and monthly thereafter. Additional weights may be obtained at the discretion of the interdisciplinary care team weights are to be obtained at the discretion of the interdisciplinary care team...purpose: to obtain baseline weight and identify significant weight change; to determine possible causes of significant weight change... NJAC 8:39-27.1(a); 27.2 (a)	F 692		
F 761 SS=E	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	F 761		4/3/23

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F 761	Continued From page 31 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and 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 facility documents, it was determined that the facility failed to maintain medication carts free from debris which included loose, unmarked, and unwrapped medications. This deficient practice was identified for 3 of 4 medication carts (Ocean low-side, Seashore high-side, Seashore low-side) on 2 of 3 nursing units (Ocean and Seaside) and the evidence was as follows: On 2/22/23 at 11:10 AM, in the presence of Licensed Practical Nurse (LPN #1), the surveyor inspected the Ocean nursing unit's low-side medication cart and observed in the second drawer, where the multiple-use medication blister packs were stored, one loose pink tablet which was unwrapped and unmarked.	F 761	1.How will corrective action be accomplished for those individuals' residents cited for this deficiency? On *Ex Order 26. 4B1* , Ocean low side, Seashore low side, and Seashore high side, all loose and unidentified pills were removed and placed in the medication rooms for destruction immediately. 2.How will we identify other resident who have potential to be affected by the same deficient Practice? All residents have the potential to be affected by this deficient practice. 3.What measure will be put in place or	

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F 761	Continued From page 32 At this time, the surveyor interviewed LPN #1 who stated she was unsure what the medication was and removed the medication from the cart for destruction. LPN #1 stated that if loose medications were found, she removed them from the cart and placed them in the medication room in the container for destruction. LPN #1 also stated the cart was checked every night shift for expired or loose medications. On 2/22/23 at 11:25 AM, in the presence of LPN #2, the surveyor inspected the Seashore nursing unit's high-side medication cart and observed the following: Inside the top drawer on the right side of the medication cart, a tablet in a small plastic cup, unmarked. LPN #2 informed the surveyor that the medication had fallen on the floor, and she meant to remove it earlier for destruction. In the second drawer which contained the multiple-use medication blister packs, five (5) tablets, one (1) capsule, and two (2) pieces of tablets all unwrapped and unmarked. LPN #2 was unable to identify the loose medications and stated that the 11:00 PM to 7:00 AM shift nurse was responsible for inspecting the cart. LPN #2 acknowledged that all nurses were responsible for inspecting their medication carts on every shift. LPN #2 removed the loose medications from the cart and brought them to the medication room for destruction. On 2/22/23 at 12:01 PM, in the presence of LPN #3, the surveyor inspected the Seashore nursing unit's low-side medication cart and observed the following:	F 761	systemic changes made to ensure that the deficient practice does not recur? Nurse Practice Educator reeducated all nursing staff on Medication Storage and Disposal. Nurse Practice Educator reeducated all nursing staff on checking medication carts for loose unidentified medications and disposing of unidentified medications properly per facility policy. Unit Managers or Designee will audit all medication carts for loose unidentified medications weekly for three months. 4.How will we monitor our Corrective action to ensure that the deficient practice is being corrected and not recur? Unit Managers or designee will bring their audits and findings and present it at the monthly QAPI Meetings for three months to ensure compliance.	

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In the top drawer, a multiple-use medication blister pack with four (4) Cefdinir 300 milligram (mg) tablets (an antibiotic used to treat infections). The multiple-use blister pack was torn and did not have a label which indicated the resident's name or room number on it.

In the second drawer which contained the multiple-use medication blister packs, two (2) capsules, 31 tablets, and seven (7) tablet pieces which were all unwrapped and unmarked.

At this time, LPN #3 acknowledged all the loose and unmarked medications should not be in the cart and need to be brought to the medication room for destruction. LPN #3 informed the surveyor that she checked the medication cart daily for expired and loose medications and acknowledged she had forgotten to check it that day.

On 2/22/23 at 12:25 PM, the surveyor interviewed the Seashore nursing unit's Unit Manager/LPN (UM/LPN) who stated that every nurse was responsible for checking their own medication carts every shift, and all unwrapped, unmarked medications should be removed from the carts and put in the medication room for destruction.

On 2/23/23 at 1:01 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) the above concerns.

On 2/24/23 at 11:27 AM, the DON in the presence of the LNHA and survey team acknowledged there should not be loose unmarked medications in the medication carts because it was an infection control concern.

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F 761	Continued From page 34 A review of the facility's "Storage and Expiration Dating of Medication, Biologicals" dated revised 7/21/22, included...facility should ensure that medications and biologicals are stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezers of sufficient size to prevent crowding...medications and biologicals that have been contaminated or deteriorated are stored separate from other medications until destroyed or returned to the pharmacy or supplier...facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels or cautionary instructions...facility should ensure that the medications and biologicals for each resident are stored in the containers in which they were originally received...facility personnel should inspect nursing station storage areas for proper storage compliance on a regular scheduled basis...facility should request that pharmacy perform a routine nursing unit inspection for each nursing station in facility to assist facility in complying with its obligations pursuant to applicable law relating to the proper storage, labeling, security and accountability of medications and biologicals.	F 761		
F 812 SS=E	NJAC 8:39-29.4(a),(h) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		4/3/23

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F 812	Continued From page 35 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) store, label, and date potentially hazardous foods to prevent food-borne illness; b.) discard potentially hazardous foods past their date of expiration; c.) maintain storage areas in a sanitary manner; d.) maintain kitchen equipment to prevent microbial growth; and e.) air dry kitchen equipment in a manner to prevent microbial growth. This deficient practice was evidenced by the following: On 2/14/23 at 9:19 AM, the surveyor toured the kitchen with the Food Service Director (FSD) and observed the following: 1. In the walk-in refrigerator, one opened quart of whole liquid eggs labeled 2/1/23 and 2/16/23. The FSD indicated the 2/1/23 was the opened date and the 2/16/23 was the discard date. The package indicated best results use within three days of opening. The FSD confirmed the eggs needed to be discarded.	F 812	1.How will corrective action be accomplished for those individuals□ residents cited for this deficiency? Food Service Director immediately discarded the liquid eggs, vanilla shake, ricotta cheese, and cottage cheese. Maintenance Director installed a new latch for the freezer door and installed a new vinyl strip on February 16, 2023. Food Service Director immediately removed ice build up on the vinyl curtain, inside the freezer door, shelves, and freezer floor. Food Service Director immediately rewashed the twelve pans identified and properly air dried. Food Service Director immediately discarded the three large rubber spatulas and placed the small rubber spatula	

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F 812	Continued From page 36 2. In the walk-in refrigerator, one defrosted vanilla health shake stored in a box labeled chocolate health shakes. The FSD stated health shakes were received frozen and stored in the freezer until ready to be used. The health shakes were then pulled from the freezer, labeled, and had to be used within fourteen days. The health shake was not labeled when pulled from the freezer or when to discard. The FSD confirmed the health shake needed to be discarded. 3. In the walk-in refrigerator, one opened five-pound container of ricotta cheese. The container was labeled opened 1/26/23, and the packaging indicated to use within five days of opening. 4. In the walk-in refrigerator, one opened five-pound cottage cheese. The container was labeled opened 2/12/23, and the packaging indicated best by 2/12/23. 5. Connected inside the walk-in refrigerator was the walk-in freezer. The freezer door was ajar and the FSD stated the door did not close properly. When the door to the freezer was opened, the surveyor observed one vinyl strip curtain located in the center of the curtains at the entrance to the freezer was missing. These curtains protect the inside of the freezer from outside dust particles as well as keep the cold air from escaping the freezer when the door was opened. The surveyor also observed an accumulation of ice on the curtains, inside freezer door, shelves, and floor. The FSD stated the ice accumulation was caused by the freezer door not closing properly. The FSD acknowledged the freezer could not have an accumulation of ice build-up in the walk-in freezer and the missing	F 812	through the high temp dish machine. Food Service Director re-educated all dietary staff on labeling and dating, expiration of food items once opened, pull dates and use by dates for freezer items, no wet nesting and proper time for air drying, dating health shakes when pulled from freezer, and mopping / removing any ice building up in walk in freezer, and discarding any cracked or stained small wares on February 14 and 23, 2023. 2.How will we identify other resident who have potential to be affected by the same deficient Practice. All residents have the potential to be affected by this deficient practice. 3 What measure will be put in place or systemic changes made to ensure that the deficient practice does not recur? Food Service Director or Designee will monitor storage areas, service ware storage, kitchen equipment, walk in refrigerator , walk in freezer, and small wares daily and be recorded on a kitchen opening and closing checklist for six weeks. Food Service Director or Designee will conduct weekly food safety inspection audits for six weeks. 4.How will we monitor our Corrective action to ensure that the deficient practice is being corrected and not recur?	

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F 812	Continued From page 37 vinyl strip curtain needed to be replaced. 6. On a drying rack, seven deep hotel pans and five two-inch full hotel pans stacked and wet nested with water in between them. The FSD confirmed the pans needed to be fully dried prior to stacking. 7. Hanging on a rack in the cooking area, three large rubber spatulas discolored and cracked. The surveyor also observed a small rubber spatula with yellow debris on it that the FSD was able to remove with his fingernail. The FSD stated the large rubber spatulas needed to be discarded and the small rubber spatula washed. On 2/24/23 at 11:27 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON) and survey team acknowledged these findings. A review of the undated facility provided "Warewashing, Manual" cleaning procedure included....place ware on a drain board, inverted to drain and air dry; do not wipe dry. A review of the facility's "Refrigerator/Frozen Storage" policy dated revised 6/15/18, included food stored under refrigerator/freezer storage is maintained in a safe and sanitary manner...all foods are labeled with the name of the product and the date received and "use by" date once opened. Manufacturer "use by" dates are used until opened...frozen, commercially prepared shakes are thawed under refrigeration; the date removed from the freezer is marked on the case. Once the shakes are thawed, a "use by" date is added to the case. Individual shakes are labeled with "use by" date when removed from the	F 812	Food Service Director or Designee will provide the results of the audits at the monthly QAPI Meeting for the next two months to ensure the deficient practices are corrected and will not recur.	

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F 812	Continued From page 38 original container...freezers are kept clean and organized. Cleaning is routinely scheduled and completed...	F 812		
F 836 SS=E	NJAC 8:39-17.2(g) License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other	F 836		4/3/23

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F 836	Continued From page 39 provisions may result in a finding of non-compliance with this paragraph. 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 maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey for 13 out of 14 day shifts reviewed during a two-week period prior to survey and for 4 of 4 day shifts observed on 2 of 3 nursing units (Seashore and Ocean) observed during survey. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified 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 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	F 836	1.How will corrective action be accomplished for those individuals□ residents cited for this deficiency? Resident #45 interviewed by Unit Manager and will now get up before breakfast as per the residents preference. The Center will maintain the state minimum direct care staff -to- resident ratios. Center Staffing Coordinator, who is a C.N.A, took assignment as well as Restorative C.N.A. in addition to three nurse managers to assist with a.m. care. Non Clinical Center staff assisted with breakfast and lunch tray pass. 2.How will we identify other resident who have potential to be affected by the same deficient Practice All residents have the potential to be affected by this deficient practice. 3.What measure will be put in place or systemic changes made to ensure that the deficient practice does not recur? Unit Managers or Designee on all units will interview all residents to find out what time preferences the residents would like to get up in the morning. Unit Manager or Designee will adjust assignment schedule	

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F 836	Continued From page 40 direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. On 2/15/23 at 12:12 PM, the surveyor interviewed Unit Manager/Licensed Practical Nurse (UM/LPN #1) on the Seashore nursing unit who stated there were four CNAs assigned to the nursing unit, but at 10:00 AM, she was informed that one CNA was not coming, so there were only three CNAs. UM/LPN #1 further stated that the census on the unit was 59. The surveyor asked UM/LPN #1 how many residents each of the CNAs were assigned, and she responded that each aide started with fifteen residents, but now had an additional four to five residents added to their assignments. On 2/15/23 at 12:30 PM, the surveyor interviewed CNA #1 on the Seashore nursing unit who stated she was on light duty and did not have assigned residents. CNA #1 stated her specific duties included passing out meal trays, feeding residents, and answering call bells. On 2/15/23 at 12:36 PM, the surveyor interviewed CNA #2 on the Seashore nursing unit who stated that she usually worked as a restorative aide, but the facility was short-staffed today, so she was given an assignment as an aide to care for residents. The surveyor asked how many residents she was assigned for the day, and CNA #2 she replied she had started out with fifteen residents, but around 12:30 PM, she was assigned five additional residents for a total of twenty residents to provide care for. At that time, the surveyor reviewed the CNA Assignment sheet for 2/15/23, which confirmed CNA #1 did not have an assignment and that	F 836	based on these identified preferences. Unit Manager or Designee will in-service C.N.As on each unit of their residents preferences and assignment sheets. Unit Managers and Nurses on all Units will assist C.N.As getting residents up in the morning based on the residents preference identified. Center will have three on site C.N.A. classes at the center for 2023 and will utilize off-site local C.N.A School, which center has an agreement with. Center will utilize the offsite C.N.A School on a monthly basis. Center Human Resource Manager or Designee will advertise and recruit for non-certified aides to send to both the onsite and offsite school. Center Human Resource Manager or Designee will advertise new rates on social media and internet job postings along with new retention bonuses. Human Resources Manager or Designee will utilize raffles to entice staff to pick up open shifts on a weekly basis. Human Resources Manager or Designee will advertise to center staff new referral bonuses to entice center staff to assist with recruitment efforts. Center leadership team including Administrator, Staffing Coordinator, Director of Nursing, Staff Educator, Human Resources, and C.N.As will meet on a weekly basis to discuss candidate flow and new hires. Staffing Coordinator or Designee will provide daily staffing ratios to the center leadership team via email and daily morning meeting and adjust or add other clinical staff as needed to meet the	

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F 836	Continued From page 41 CNA #2 was assigned twenty residents for that shift. On 2/15/23 at 1:14 PM, the surveyor interviewed the Director of Nursing (DON) who stated that there were four CNAs assigned to the Seashore nursing unit today. The surveyor reviewed with the DON a copy of the CNA Assignment sheet provided by UM/LPN #1, which reflected there were three CNAs with assignments. The DON then acknowledged that the fourth CNA (CNA #1) was on light duty and did not have an assignment. On 2/16/23 at 9:29 AM, the surveyor interviewed the Ocean nursing unit's UM/LPN #2 who stated that the census on the unit was 57, and there were five CNAs working on the unit plus one light duty CNA (CNA #3) who, "can't take an assignment". UM/LPN #2 explained that the duties of the light duty aide included passing out meal trays and feeding residents. UM/LPN #2 stated that each CNA had eleven or twelve residents on their assignments for that shift. On 2/16/23 at 9:41 AM, the surveyor interviewed CNA #3 who confirmed she was on light duty and did not have an assignment. On 2/16/23 at 9:45 AM, the surveyor interviewed CNA #4 on the Ocean unit who stated that she had twelve residents on her assignment. At that time, the surveyor reviewed the CNA Assignment sheet for 2/16/23, which confirmed that CNA #4 was assigned twelve residents for that shift. On 2/16/23 at 11:24 AM, the surveyor interviewed	F 836	required ratio. 4.How will we monitor our Corrective action to ensure that the deficient practice is being corrected and not recur? Staffing Coordinator or Designee will provide daily staffing ratios to the center leadership team via email and daily morning meeting and adjust as needed. Human Resource Manager or Designee will provide a Quality Improvement Project update at the monthly QAPI Meeting on recruitment efforts and new hire C.N.As on a monthly basis x 12 months. The QAPI Committee will determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is needed. Unit Managers or Designee will update any changes or new resident preferences in resident's daily routine at daily morning meeting and C.N.A Assignment sheet.	

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CNA #5 on the Ocean unit who stated she had twelve residents on her assignment for that shift. CNA #5 further stated that she usually had ten residents on her assignment, but today the unit was short and only had five CNAs, so she ended up with twelve residents.

On 2/16/23 at 11:32 AM, the surveyor interviewed CNA #6 on the Ocean unit who stated she had twelve residents assigned to her for the day. CNA #6 stated that "on a good day" she had 10 residents on her assignment. CNA #6 further stated that the unit had five CNAs today, but often had only two, three, or four CNAs scheduled for the day, and she usually had 16 residents on her assignment.

The surveyor reviewed the CNA Assignment sheet for the Ocean nursing unit which revealed there were five CNAs assigned to 57 residents. The sheet also confirmed CNA #5 and CNA #6 were each assigned twelve residents.

On 2/16/23 at 11:41 AM, UM/LPN #2 provided the surveyor with a list of alert and oriented residents on the Ocean nursing unit.

On 2/16/23 at 11:55 AM, the surveyor observed Resident #45 on the Ocean unit seated in a wheelchair in his/her room. The alert and oriented resident stated that he/she was assisted out of bed at 11:00 AM this morning. The resident further stated that his/her preference was to get out of bed before breakfast and stated, "I hate to say it but sometimes they only have three CNAs, and I am left in bed all day."

On 2/16/23 at 12:18 PM, the surveyor interviewed UM/LPN #1 on the Seashore nursing unit who

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stated that the census on the unit was 56 and there were four CNAs on the unit with each CNA assigned 14 residents. UM/LPN #1 further stated that each CNA should only have eight residents assigned to them, and the expectation was that each resident received care and be out of bed by 11:00 AM.

On 2/16/23 at 12:25 PM, the surveyor interviewed CNA #7 who stated that she had fourteen residents on her assignment this shift.

On 2/16/23 at 12:30 PM, the surveyor interviewed CNA #2 who stated that she had fifteen residents on her assignment this shift. CNA #2 further stated that she had not provided care to Resident #58 yet because she had fifteen residents on her assignment. The surveyor observed Resident #58 was still in bed.

The surveyor reviewed the CNA Assignment sheet for 2/16/23, which revealed there were four CNAs assigned to fifty-six residents. The sheet also revealed CNA #7 was assigned to fourteen residents and CNA #2 was assigned to fifteen residents.

On 2/22/23 at 9:23 AM, the surveyor interviewed UM/LPN #2 who stated that the census on the Ocean nursing unit was 58; the unit had five CNAs plus one light duty aide (who did not have an assignment); and each CNA had twelve residents on their assignments.

On 2/22/23 at 11:59 AM, the surveyor interviewed CNA #8 who stated she had sixteen residents on her assignment. CNA #8 stated that she still had six residents to provide morning care for. CNA #8 further stated that she preferred to have all

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residents' care completed prior to lunch meal, but she was unable to do that today due to the number of residents she had on her assignment this shift.

On 2/23/23 at 9:07 AM, the surveyor interviewed the Human Resources Director (HRD) who was the acting staff coordinator when the Staff Coordinator was out. The HRD stated she made the nursing schedules, and that the facility was staffed according to the census. The HRD further stated that the facility's ultimate goal was to meet the regulation ratio for the day shift which was one CNA to eight residents. The HRD acknowledged that the facility had not met the one to eight ratio for the day shift for the Seashore or Ocean nursing units on 2/15/23, 2/16/23, 2/22/23, or 2/23/23.

On 2/23/23 at 11:53 AM, the surveyor interviewed UM/LPN #2 who stated that the census on the unit was 58; they had four CNAs on the floor; and each CNA had fourteen or fifteen residents assigned to them.

On 2/23/23 at 1:00 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) and DON the above concerns.

On 2/24/23 at 11:32 AM, the DON in the presence of the LNHA and survey team acknowledged that the facility was not meeting the one CNA to eight residents ratio on a daily basis, and further stated that the facility's expectation was that all residents received morning care by 11:00 AM.

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F 836	Continued From page 45 2. During entrance conference on 2/14/23 at 9:48 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON) informed the surveyor that the facility was good on staffing. The LNHA continued that during the *Ex Order 26. 4B1* [redacted], the facility struggled with staff and utilized Agency staff. The LNHA stated the facility no longer used Agency staff, and the facility had an on-site CNA training school, so the facility utilized Non-Certified Aides (NAs) to assist the CNAs. At this time, the surveyor requested the facility to complete the "Nurse Staffing Report" for the past two weeks. A review of the "Nurse Staffing Report" completed by the facility for the weeks of 1/29/23 to 2/4/23 and 2/5/23 to 2/11/2, which revealed the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below: 1/29/23 had 12 CNAs for 148 residents on the day shift, required 18 CNAs. 1/30/23 had 15 CNAs for 147 residents on the day shift, required 18 CNAs. 1/31/23 had 12 CNAs for 147 residents on the day shift, required 18 CNAs. 2/1/23 had 12 CNAs for 146 residents on the day shift, required 18 CNAs. 2/2/23 had 15 CNAs for 146 residents on the day shift, required 18 CNAs. 2/3/23 had 14 CNAs for 145 residents on the day shift, required 18 CNAs. 2/4/23 had 12 CNAs for 145 residents on the day shift, required 18 CNAs. 2/5/23 had 10 CNAs for 144 residents on the day shift, required 18 CNAs. 2/6/23 had 11 CNAs for 144 residents on the day shift, required 18 CNAs.	F 836		

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F 836	Continued From page 46 2/7/23 had 14 CNAs for 144 residents on the day shift, required 18 CNAs. 2/9/23 had 13 CNAs for 144 residents on the day shift, required 18 CNAs. 2/10/23 had 14 CNAs for 144 residents on the day shift, required 18 CNAs. 2/11/23 had 14 CNAs for 144 residents on the day shift, required 18 CNAs. On 2/24/23 at 11:27 AM, the LNHA in the presence of the DON and survey team acknowledged the facility did not always meet the one CNA to eight residents ratio for the day shift.	F 836		
F 880 SS=E	NJAC 8:39-5.1(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	F 880		4/3/23

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F 880	Continued From page 47 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 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	F 880		

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F 880	Continued From page 48 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, and review of pertinent facility documents, it was determined that the facility failed to ensure: a.) a resident with an Ex Order 26. 4B1 received shift and daily care in accordance with manufacturer's instructions including changing of the Ex Order 26. 4B1 every eight to twelve hours, daily maintenance of the system, and storage off the floor to prevent infection since Ex Order 26. 4B1 and b.) housekeeping staff were cleaning resident rooms from well to ill (Ex Order 26. 4B1) in accordance with facility policy and national guidance for infection control during a Ex Order 26. 4B1 outbreak to mitigate the spread of the disease. This deficient practice was identified for 1 of 5 residents (Resident #22) reviewed for Ex Order 26. 4B1 and 1 of 3 nursing units (Seashore) and was evidenced by the following: 1. On 2/14/23 at 11:03 AM, the surveyor observed Resident #22 lying in bed. The resident was covered in a blanket and the surveyor observed Ex Order 26. 4B1 coming from underneath the blanket connected to a closed container lying directly on the floor. The resident informed the surveyor that he/she had Ex Order 26. 4B1 . On 2/15/23 at 11:42 AM, the surveyor observed the resident in bed watching television. The surveyor observed the Ex Order 26. 4B1 coming from underneath the resident's blanket connected	F 880	1.How will corrective action be accomplished for those individuals□ residents cited for this deficiency? For resident # 22, a physician order was obtained for use of the external female Ex Order 26. 4B1 . The order reflects that the patient will receive shift and daily care in accordance with the manufacturers recommendations. While in use, the canister will be placed on a surface off the floor for infection prevention and covered with a privacy cover. The care plan for resident # 22 has been updated to reflect use of the Ex Order 26. 4B1 along with the patient's preference for the unit to be stored next to the bed where she is unable to see it. The Infection Preventionist and Nurse Practice Educator immediately provided re-education to the Environmental Services Director and all housekeeping staff to clean rooms of well residents first and then proceed to the rooms of residents on Transmission Based Precautions, well to ill. 2.How will we identify other resident who have potential to be affected by the same deficient Practice?	

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F 880	Continued From page 49 to a closed container lying directly on the floor. The resident informed the surveyor the tubes were from a [name redacted] *Ex Order 26. 4B1* [redacted]. The surveyor reviewed the medical record for Resident #22. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in *Ex Order 26. 4B1* with diagnoses which included *Ex Order 26. 4B1* [redacted]. A review of the most recent admission Minimum Data Set (MDS), an assessment tool *Ex Order 26. 4B1*, reflected the resident had a *Ex Order 26. 4B1* [redacted] score of [redacted] out of 15, which indicated a *Ex Order 26. 4B1* [redacted]. A review of "Section [redacted]. Bladder and Bladder", revealed the resident was always *Ex Order 26. 4B1* [redacted]. A review of the Physician Orders did not include a physician order for an *Ex Order 26. 4B1* [redacted]. A review of the individualized person-centered care plan included a focus area initiated *Ex Order 26. 4B1*, for the resident is *Ex Order 26. 4B1* [redacted] and is unable to *Ex Order 26. 4B1* [redacted] participate in a retraining due to other *Ex Order 26. 4B1* [redacted]	F 880	All residents have the potential to be affected by this deficient practice. 3.What measure will be put in place or systemic changes made to ensure that the deficient practice does not recur? All patients and residents who utilize an external female catheter urinary collection system will have a physician order present for use of the system. It will be placed on the Treatment Administration Record and it will be included in the individualized person-centered care plan. Nursing documentation will reflect use and effectiveness of the drainage system. All licensed nursing staff will be reeducated by the Nurse Practice Educator, on use of the female external catheter urinary collection systems, per manufacturer's guidelines. This will be documented on the Treatment Administration Record. All licensed nurses will be re-educated that the system must be stored off the floor to prevent spread of infection by the Nurse Practice Educator. All patients/residents will require a physician order, care plan and nursing documentation if the system is to be utilized. A weekly audit will be performed by Unit Managers for any patient/resident utilizing the system for three months to demonstrate compliance. Environmental Services Director will audit housekeepers two times a week for three months for compliance with cleaning	

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F 880	Continued From page 50 Ex Order 26. 4B1. Interventions included to assist with NJ Exec. Order 26:4.b.1 as needed; provide privacy and comfort; and use absorbent products as needed. The care plan did not include the resident's *Ex Order 26. 4B1* . A review of the Progress Notes did not include the resident's *Ex Order 26. 4B1* . On 2/17/23 at 11:40 AM, the surveyor observed the resident in bed with the *Ex Order 26. 4B1* lying directly on the floor next to the resident's bed. On 2/21/23 at 11:56 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated the resident needed assistance with care. The CNA continued that the resident had an *Ex Order 26. 4B1* that the nurse took care of. The CNA stated the nurse was in charge of the Ex Order 26. 4B1 placement as well as emptying out the Ex Order 26. 4B1 of the collection system. The CNA stated if the *Ex Order 26. 4B1* was not placed correctly, the Ex Order 26. would leak onto the *Ex Order 26. 4B1* brief. The CNA stated she changed the resident's *Ex Order 26. 4B1* brief every shift. On 2/21/23 at 12:07 PM, the surveyor observed the resident in bed and the *Ex Order 26. 4B1* lying directly on the floor. The resident informed the surveyor that he/she had the *Ex Order 26. 4B1* prior to coming to the facility, and they continued to have the system since they have been here. The resident stated they need the *Ex Order 26. 4B1* to keep their Ex Order 26. 4B1 on their Ex Order 26. 4B1 dry. The resident stated the nurse took care of the *Ex Order 26. 4B1*	F 880	rooms of well residents to rooms of residents on Transmission Based Precautions. 4. How will we monitor our Corrective action to ensure that the deficient practice is being corrected and not recur? Unit Managers and Environmental Services Director will present the results of the audits at the monthly QAPI Meeting for three months to ensure compliance. DPOC - Date of Compliance 3/27/23 1. Root Cause Analysis conducted and completed by Nursing Home Administrator, Director of Nursing, Infection Preventionist, Nurse Practice Educator, and Medical Director. 2. All required videos have been viewed/completed by staff by 3/23/23. Module 1 - Infection Prevention & Control Program Topline Staff and Infection Preventionist CDC Covid-19 Prevention Message for Front Line Long-Term Care Staff: Keep Covid-19 out! - Frontline Staff CDC Covid-19 Prevention Messages for Front Line Long Term Care Staff: Sparkling Surfaces - Frontline Staff CDC Covid-19 Prevention Messages for Front Line Long-Term Care Staff: Use PPE Correctly for Covid-19 - Frontline Staff Module 5 - Outbreaks Topline Staff and Infection Preventionist	

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F 880	Continued From page 51 and they were unsure how often any care was performed to the [redacted] by the nurse. The resident stated they assumed the [redacted] was changed by the nurse when it should be changed, but the resident could not speak to if the [redacted] was changed at least daily. At this time, the resident did not [redacted] associated with the [redacted], but they did say the [redacted] just slipped out of place which caused [redacted] to get on their [redacted] which was causing a [redacted] to their [redacted]. At this time, the resident pressed the call bell for assistance. On 2/21/23 at 1:16 PM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN), who stated the resident had an [redacted] that they were admitted to the facility with for their [redacted] to prevent any kind of damage to the [redacted]. The LPN stated when the resident [redacted], the seal around [redacted] loosened and the [redacted] tended to get on the [redacted]. The LPN stated the nurses emptied the collection canister when it was halfway filled. The LPN also stated the nurses verified there was suction present to the [redacted] which was '[redacted]" that went around the resident's '[redacted]". The LPN stated if there was no suction that could be heard from the wand, or the resident's [redacted] brief was wet because the [redacted] was no longer sucking, the nurse needed to change the [redacted]. The LPN stated there was no set times or dates when the [redacted] was to be changed; the nurse just checked to ensure the [redacted] was still sucking, and if not, the [redacted] had to be changed. The	F 880	Module 11B - Environmental Cleaning and Disinfection All Staff including Topline staff and Infection Preventionist Module 6A - Principles of Standard Precautions All Staff including Topline staff and Infection Preventionist	

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F 880	Continued From page 52 LPN stated the Ex Order 26. 4B1 did not need to be changed every shift or even daily; it was changed when it stopped sucking the Ex Order 26. 1. The surveyor asked if the *Ex Order 26. 4B1* should be stored directly on the floor, and the LPN responded, "should not ideally been on the floor." When asked why it should not be on the floor, the LPN stated it was an infection control issue, but the resident did not want to see the machine. On 2/21/23 at 1:34 PM, the surveyor asked the LPN to review the physician's order (PO) and confirm if there was a PO for the external *Ex Order 26. 4B1*. The LPN checked the PO, and stated there was now a PO dated Ex Order 26. 4B1 to change the *Ex Order 26. 4B1* every eight hours. The surveyor continued to review the resident's medical record. A review of the *Ex Order 26. 4B1* Medication Administration Record (MAR) did not include the *Ex Order 26. 4B1* being changed every eight hours or daily. There was no record of the *Ex Order 26. 4B1*. A review of the *Ex Order 26. 4B1* Treatment Administration Record (TAR) did not include the *Ex Order 26. 4B1* being changed every eight hours or daily. There was no record of the *Ex Order 26. 4B1*. On 2/21/23 at 1:38 PM, the surveyor accompanied by the LPN went to Resident #22's room. The LPN confirmed the *Ex Order 26. 4B1* was lying directly on the floor. The LPN stated the resident did not want the system stored on the table. The surveyor asked	F 880		

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F 880	Continued From page 53	F 880		

if there was something lower to the ground than a table the system could be placed on, the LPN stated there was probably something they could do to store the system off the floor and not on a table next to the resident. The LPN confirmed it was an infection control issue.

On 2/21/23 at 1:40 PM, the surveyor interviewed the Unit Manager/LPN (UM/LPN) who stated she had been out of the facility for a week and just returned. The UM/LPN stated that care plans were completed by the unit managers as well as supervisors, but any nurse could initiate a care plan. The UM/LPN stated that she had noticed the resident did not have a care plan for the Ex Order 26. 4B1, so she had just added it today. The UM/LPN confirmed there should have been a care plan since the system was implemented. The UM/LPN confirmed the resident had the Ex Order 26. 4B1 since they were admitted to the facility in the beginning of Ex Order 26. 4B1; that the resident's family requested it since the resident used the system at home. The UM/LPN confirmed there was no PO for the Ex Order 26. 4B1; she thought there was one, but she added one today. The UM/LPN confirmed you would need a PO for the Ex Order 26. 4B1. The UM/LPN stated the Ex Order 26. 4B1 needed to be changed every eight hours according to manufacturer's instructions which she printed out today. The UM/LPN stated changing the Ex Order 26. 4B1 would be something that the nurses would need to sign every shift on the TAR, and the UM/LPN confirmed prior to today, staff were not documenting the Ex Order 26. 4B1 changing. The UM/LPN stated that staff were aware to change the Ex Order 26. 4B1 every eight hours. The UM/LPN confirmed you needed a PO for this, and nursing staff were expected to call the physician to obtain

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F 880	Continued From page 54 an order. The UM/LPN stated that the resident did not want the Ex Order 26. 4B1 system on the table next to them, so they were storing it on the floor which was okay since the actual canister was not touching the floor. On 2/21/23 at 2:05 PM, the surveyor interviewed the Director of Nursing (DON) who stated you would need a PO for the Ex Order 26. 4B1 , and staff would need to perform care daily. The DON stated the Ex Order 26. 4B1 system could not be placed directly on the floor for infection control purposes. The DON stated even if the resident requested the Ex Order 26. 4B1 system on the floor, the facility would have to find a lower table or cover it with a Ex Order 26. 4B1 ; the system directly on the floor was an infection control issue. The surveyor requested a policy for the Ex Order 26. 4B1 . On 2/22/23 at 11:12 AM, the surveyor observed Resident #22 in bed asleep. The Ex Order 26. 4B1 was placed off the floor with a Ex Order 26. 4B1 . On 2/22/23 at 11:23 AM, the surveyor interviewed the Infection Preventionist/Registered Nurse (IP/RN) who stated the Ex Order 26. 4B1 for an Ex Order 26. 4B1 need to be changed at least once a shift, and the Ex Order 26. 4B1 canister need to be emptied every shift or more frequently if the canister was full. The surveyor asked why the Ex Order 26. 4B1 needed to be changed every shift, the IP/RN stated you "would not want left indefinitely because it would get gross." The Ex Order 26. 4B1 drew up Ex Order 26. so if left there for days, the system would start smelling. The IP/RN also continued there could be bacterial growth on it.	F 880		

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F 880	Continued From page 55	F 880		

The IP/RN stated from an infection control standpoint, the [redacted] would need to be changed at least two to three times a day per manufacturer's instructions. The IP/RN also confirmed the [redacted] system could not be stored directly on the floor for infection control purposes, and confirmed even if resident requested, would not put directly on the floor, would have to elevate it.

On 2/22/23 at 1:12 PM, the DON stated the facility had no policy for the [redacted]; that nurses would be expected to follow the manufacturer's instructions. The DON also acknowledged the nurses should be changing the [redacted] per manufacturer's instructions for infection control purposes; nurses should not be waiting for the machine to stop sucking in order to change.

On 2/24/23 at 11:27 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA) and survey team acknowledged the resident did not have a physician order or care plan for the [redacted], and there was no documentation that the [redacted] was being changed every eight hours until it was noticed during survey. The DON also stated the tubing and canister needed to be replaced daily.

A review of the manufacturer's instructions for the "Purewick System" dated 2022, included...Maintenance replace the "Purewick [redacted]" at least every 8 to 12 hours or if soiled by [redacted]. Assess skin for compromise and perform [redacted] care prior to placement of a new "Purewick [redacted]"...Cleaning Instructions and

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F 880	Continued From page 56 Maintenance. The Ex Order 26. 4B1 canister, canister lid, Ex Order 26. 4B1, Ex Order 26. 4B1, and "Purewick Ex Order 26. 4B1 " base should be cleaned and disinfected at the time of each use, or at minimum daily. the power cord should be cleaned and disinfected at the time of each use, or at minimum daily... 2. On 2/21/23 at 10:25 AM, the surveyor interviewed the DON who stated the entire Seashore nursing unit staff were all wearing personal protective equipment (PPE) N95 (respirator) masks and face shields due to the recent increase in Ex Order 26. 4B1 cases on the unit. On 2/21/23 at 10:53 AM, the surveyor observed a Housekeeper (HK) on the Seashore unit enter Resident Room #111, wearing a reusable gown, N95 mask, face shield, and gloves. The surveyor observed a sign on the door that indicated the resident was on Ex Order 26. 4B1 which included contact and droplet precautions. The HK closed the door behind her. On 2/21/23 at 11:00 AM, the surveyor observed the HK exit Resident Room #111, and while standing in the doorway of room, the HK doffed (removed) her gown placed it into a garbage bag and placed the garbage bag in a black trash barrel in the hallway. The HK then used alcohol-based hand rub (ABHR); donned (put on) gloves and proceeded to enter Resident Room #113. The surveyor observed no signs that indicated the resident or residents in the room were on any type of Ex Order 26 including contact or droplet precautions.	F 880		

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F 880	Continued From page 57 On 2/21/23 at 11:15 AM, the surveyor observed the HK exit Resident Room [NJ Exec. Ord.], and proceeded to the housekeeping closet. At this time, the surveyor interviewed the HK who stated that she had received education from the Nurse Educator about how to don and doff her PPE, but she was not instructed by the Nurse Educator or the Environmental Services Director (ESD) regarding which order she should clean rooms on her assignment with regards to *Ex Order 26. 4B1* . On 2/21/23 at 11:20 AM, the surveyor interviewed the ESD who stated on *Ex Order 26. 4B1* units, the housekeepers were expected to don full PPE which included a gown, gloves, N95 mask, and face shield prior to entering any room that had a sign outside the door indicating [Ex Order 26]. The ESD continued that the housekeepers would go down one side of the hallway and then proceed back up the hallway on the other side cleaning from room to room. The ESD confirmed that the housekeepers cleaned rooms in room order and not based on their [Ex Order 26] status; meaning the housekeepers could clean a resident's room on [Ex Order 26], doff their PPE, and then proceed into a resident's room not on [Ex Order 26] (known as well room) and clean. The ESD stated the housekeepers were only expected to doff their PPE prior to leaving a *Ex Order 26. 4B1* resident's room and could not wear the same PPE in another resident's room. On 2/21/23 at 1:17 PM, the surveyor interviewed the facility's Infection Preventionist/Registered Nurse (IP/RN) and informed her of the observation of the HK cleaning a *Ex Order 26. 4B1* [redacted] room (Resident Room #111), and then	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315364	A. BUILDING _____ B. WING _____	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE CENTER	3 INDUSTRIAL WAY EAST EATONTOWN, NJ 07724

(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 58 proceeded to clean a non-Ex Order 26. 4B1 room (Resident Room #113). The IP/RN stated the HK should absolutely not have gone from a Ex Order 26. 4B1 room to a non-Ex Order 26. 4B1 (well) room. The IP/RN stated the HK was expected to clean the resident rooms not on Ex Order 26 first and then clean the resident's rooms on Ex Order 26. The IP/RN stated the facility used a well to ill (Ex Order 26. 4B1) cleaning schedule for infection control purposes to mitigate the spread of Ex Order 26. 4B1. The surveyor informed the IP/RN that when they interviewed the ESD, he stated the HK would clean up the hallway and back down regardless of Ex Order 26. 4B1 status in the room; as long as the HK doffed prior to entering the next room. The IP/RN stated the ESD had attended an in-service the day before which included to go from well resident rooms to ill resident rooms and other information to be mindful of during an outbreak. On 2/24/23 at 11:42 AM, the LNHA and the DON in the presence of the survey team acknowledged that all staff including housekeeping must work well to ill to help prevent the spread of illness. A review of the facility's undated "Outbreak Response Plan" included...the Facility closely monitors all Centers for Disease Control (CDC), New Jersey Department of Health Communicable Disease Services (CDS), New Jersey Department of Health (NJDOH), Centers for Medicaid & Medicare Services(CMS) and Local Board of Health (LHD) guidelines and directives for information regarding any outbreak new or reemerging infectious disease detected in the geographic region of the facility. If a new/reemergence disease is detected, the Facility will follow its Infection Control policies and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315364	A. BUILDING _____ B. WING _____	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE CENTER	**3 INDUSTRIAL WAY EAST EATONTOWN, NJ 07724**

(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 59 procedures set forth...the Facility will cohort residents, patients, equipment and staff, to the extent possible, according to the most current Governmental Guidelines & Directives... NJAC 8:39-19.4(a)(b); 27.1(a)	F 880		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	62214	A. BUILDING: _____ B. WING _____	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE CENTER	3 INDUSTRIAL WAY EAST EATONTOWN, NJ 07724

(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 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: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 13 out of 42 shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	1.How will corrective action be accomplished for those individuals□ residents cited for this deficiency? The Center will maintain the state minimum direct care staff -to- resident ratios. Center Staffing Coordinator, who is a C.N.A, took assignment as well as Restorative C.N.A. in addition to three nurse managers to assist with a.m. care. Non Clinical Center staff assisted with breakfast and lunch tray pass with all hands on deck program. 2.How will we identify other resident who	4/3/23

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

Electronically Signed | 03/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	62214	A. BUILDING: _____ B. WING _____	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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) COMPLETE DATE
S 560	Continued From page 1 nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer 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. During entrance conference on 2/14/23 at 9:48 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON) informed the surveyor that the facility was good on staffing. The LNHA continued that during the COVID-19 pandemic, the facility struggled with staff and utilized Agency staff. The LNHA stated the facility no longer used Agency staff, and the facility had an on-site CNA training school, so the facility utilized Non-Certified Aides (NAs) to assist the CNAs. At this time, the surveyor requested the facility to complete the "Nurse Staffing Report" for the past two weeks. A review of the "Nurse Staffing Report" completed by the facility for the weeks of 1/29/23 to 2/4/23 and 2/5/23 to 2/11/2, which revealed the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below: 1/29/23 had 12 CNAs for 148 residents on the	S 560	have potential to be affected by the same deficient Practice? All Residents have the potential to be affected by this deficient practice. 3.What measure will be put in place or systemic changes made to ensure that the deficient practice does not recur? Center will have three on site C.N. A. classes at the center for 2023 and will utilize off-site local C.N.A School, which center has an agreement with. Center will utilize the offsite C.N.A School on a monthly basis. Center Human Resource Manager or Designee will advertise and recruit for non-certified aides to send to both the onsite and offsite school. Center Human Resource Manager or Designee will advertise new rates on social media and internet job postings along with new retention bonuses. Human Resources Manager or Designee will utilize raffles to entice staff to pick up open shifts on a weekly basis. Human Resources Manager or Designee will advertise to center staff new referral bonuses to entice center staff to assist with recruitment efforts. Center leadership team including Administrator, Staffing Coordinator, Director of Nursing, Staff Educator, Human Resources, and C.N.As will meet on a weekly basis to discuss candidate flow and new hires. Staffing Coordinator or Designee will provide daily staffing ratios to the center leadership team via email and daily morning meeting and adjust or add other clinical staff as needed.	

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	62214	A. BUILDING: _____ B. WING _____	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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) COMPLETE DATE
S 560	Continued From page 2 day shift, required 18 CNAs. 1/30/23 had 15 CNAs for 147 residents on the day shift, required 18 CNAs. 1/31/23 had 12 CNAs for 147 residents on the day shift, required 18 CNAs. 2/1/23 had 12 CNAs for 146 residents on the day shift, required 18 CNAs. 2/2/23 had 15 CNAs for 146 residents on the day shift, required 18 CNAs. 2/3/23 had 14 CNAs for 145 residents on the day shift, required 18 CNAs. 2/4/23 had 12 CNAs for 145 residents on the day shift, required 18 CNAs. 2/5/23 had 10 CNAs for 144 residents on the day shift, required 18 CNAs. 2/6/23 had 11 CNAs for 144 residents on the day shift, required 18 CNAs. 2/7/23 had 14 CNAs for 144 residents on the day shift, required 18 CNAs. 2/9/23 had 13 CNAs for 144 residents on the day shift, required 18 CNAs. 2/10/23 had 14 CNAs for 144 residents on the day shift, required 18 CNAs. 2/11/23 had 14 CNAs for 144 residents on the day shift, required 18 CNAs. On 2/24/23 at 11:27 AM, the LNHA in the presence of the DON and survey team acknowledged the facility did not always meet the one CNA to eight residents ratio for the day shift. NJAC 8:39-5.1(a)	S 560	4.How will we monitor our Corrective action to ensure that the deficient practice is being corrected and not recur? Human Resource Manager or Designee will provide a Quality Improvement Project update at the monthly QAPI Meeting on recruitment efforts and new C.N.A. hires on a monthly basis x 12 months. The QAPI Committee will determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is needed.	
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step [redacted]	S1410		4/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1410	Continued From page 3 *Ex Order 26. 4B1* with five *Ex Order 26. 4B1* units of purified protein derivative. The only exceptions shall be employees with documented negative two-step *Ex Order 26. 4B1* within the last year, employees with a documented positive *Ex Order 26. 4B1* result (*Ex Order 26. 4B1*), employees who have received appropriate medical treatment for *Ex Order 26. 4B1*, or when medically contraindicated. Results of the *Ex Order 26. 4B1* administered to new employees shall be acted upon as follows: 1. If the first step of the *Ex Order 26. 4B1* result is less than *Ex Order 26. 4B1*, the second step of the two-step *Ex Order 26. 4B1* shall be administered one to three weeks later. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to perform a two-step *Ex Order 26. 4B1* as required for new employees hired for *Ex Order 26. 4B1* for infection and disease screening . This deficient practice was identified for 4 of 5 employee files (Staff #1, #2, #3, & #4) reviewed and was evidenced by the following: On 2/23/23 at 9:00 AM, the surveyor reviewed five randomly selected new employee health files for *Ex Order 26. 4B1* which revealed the following:	S1410	1.How will corrective action be accomplished for those individuals□ residents cited for this deficiency? The four employees who did not have the two step *Ex Order 26. 4B1* completed/recorded were-administered the two step *Ex Order 26. 4B1*. Results were recorded on the *Ex Order 26. 4B1* form and placed in their health file. 2.How will we identify other resident who have potential to be affected by the same	

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S1410	Continued From page 4 Staff #1, a Registered Nurse (RN), hired Ex Order 26. 4B1, received their first dose on Ex Order 26. 4B1, and the results were read on Ex Order 26. 4B1. The first dose results were negative. There was no evidence a second dose was administered. Staff #2, a Certified Nursing Aide (CNA), hired Ex Order 26. 4B1, received their first dose on Ex Order 26. 4B1, and the results were read on Ex Order 26. 4B1. The first dose results were negative. There was no evidence a second dose was administered. Staff #3, a RN, hired Ex Order 26. 4B1, received their first dose on Ex Order 26. 4B1, and the results were read on Ex Order 26. 4B1. The first dose results were negative. There was no evidence a second dose was administered. Staff #4, a Licensed Practical Nurse (LPN), hired Ex Order 26. 4B1, received their first dose on Ex Order 26. 4B1, and the results were read on Ex Order 26. 4B1. There was no evidence a second dose was administered. On 2/23/23 at 9:25 AM, the surveyor interviewed the Director of Nursing (DON) who stated the Infection Preventionist/RN (IP/RN) was in charge of employee health screening. On 2/23/23 at 10:13 AM, the surveyor interviewed the IP/RN who confirmed she was in charge of employee health screening for newly hired employees. The IP/RN stated upon hire, the employees were administered a health physical by a physician or nurse practitioner, and they received a one-step Ex Order 26. 4B1. When asked why the employee did not receive the second step, the IP/RN responded that the state had a low Ex Order rate so only one dose was required. At this time, the surveyor requested documentation from the state that only one of a two-step Ex Order 26 tested should be	S1410	deficient Practice? All residents have the potential to be affected by this deficient practice. 3.What measure will be put in place or systemic changes made to ensure that the deficient practice does not recur? Infection Preventionist or Designee will be responsible for all employee health records and will ensure the two step *Ex Order 26. 4B1* is given to all new and re-hired employees unless they have a history of positive results or have proof it was given to them in the past year. All current eligible employees will be audited and scheduled for the two step Ex Order 26. 4B1 and have a completion date of *Ex Order 26. 4B1*. 4.How will we monitor our Corrective action to ensure that the deficient practice is being corrected and not recur? Infection Preventionist or Designee will present findings of audits at the monthly QAPI meeting for three months and ensure compliance.	

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S1410	Continued From page 5 performed as well as a copy of the facility's [Ex Orde] policy. On 2/23/23 at 11:55 AM, the IP/RN informed the surveyor that she was unable to locate information regarding the administration of only one of a two-step [Ex Order 26. 4B] . The IP/RN provided the surveyor a copy of the facility's policy, and she acknowledged the policy included to follow the state's regulation. The IP/RN stated that the facility always administered the two-step [Ex Order 26.], but recently in the past year or two maybe stopped administering the second dose if the first dose was negative. The IP/RN could not speak to exactly when the facility stopped, but she recalled reading somewhere that the second step was not required anymore. On 2/23/23 at 1:17 PM, the IP/RN provided the surveyor with a copy of from their Corporate Office which indicated the state was no longer requiring a two-step [Ex Order 26. 4B] that the state was following the guidance of the Centers for Disease Control (CDC). The IP/RN was unable to provide any documentation from the state. On 2/24/23 at 11:27 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the DON and survey team acknowledged that the facility should have been administering a two-step [Ex Order 26. 4B] to all new employees upon hire. A review of the facility's "Tuberculosis Screening" policy dated revised 11/1/21, included...TB screening is conducted for new employees including a symptom evaluation, an individual TB risk assessment, and screening test [BAMT or TST] (Blood Assay for M Tuberculosis or tuberculin skin test) for those without documented prior TB disease or latent TB	S1410		

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S1410	Continued From page 6 infection...administration of BAMT or TST for employees will be conducted in accordance with state regulations...Dosage Administration of the TST Mantoux Test: one-tenth milliliter of 5 tuberculin strength purified protein derivative (PPD) tuberculin antigen is injected intradermally on the volar surface of the forearm...Two-step Method: administer dosage as outlined above and read (interpret) the test result in 48-72 hours. If results are negative, proceed with step two (administer dosage as outlined in process 3 above) within one to three weeks after the first TST result was read... NJAC 8:39-19.5(b)	S1410		

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
315364 Y1	A. Building B. Wing Y2	4/4/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE CENTER	3 INDUSTRIAL WAY EAST EATONTOWN, NJ 07724

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 F0550	Correction	ID Prefix F0609	Correction	ID Prefix F0610	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.12(c)(2)-(4)	Completed
LSC	04/03/2023	LSC	04/03/2023	LSC	04/03/2023
ID Prefix F0689	Correction	ID Prefix F0692	Correction	ID Prefix F0761	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(g)(1)-(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	04/03/2023	LSC	04/03/2023	LSC	04/03/2023
ID Prefix F0812	Correction	ID Prefix F0836	Correction	ID Prefix F0880	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.70(a)-(c)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	04/03/2023	LSC	04/03/2023	LSC	04/03/2023
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	
2/28/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
62214	A. Building B. Wing	4/4/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE CENTER	3 INDUSTRIAL WAY EAST EATONTOWN, NJ 07724

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 04/03/2023	ID Prefix S1410 Reg. # 8:39-19.5(b)(1) LSC	Correction Completed 04/03/2023	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

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 2/28/2023	☐ 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
	315364	A. BUILDING **01** B. WING _____	**02/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE CENTER	**3 INDUSTRIAL WAY EAST** **EATONTOWN, NJ 07724**

(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 000	INITIAL COMMENTS The nursing home building construction was stated to be 1990s with no current major renovations or noted additions. It is a two story building Type I (222) fire resistant construction and is fully sprinklered. The exterior 150 KW diesel generator does approximately 50% of the building. The facility has 13 smoke zones and is divided into 3-wings: Floor-2: Ocean wing Floor-1: Seashore wing Floor-1: Navesink wing 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 utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 158 certified beds. At the time of the survey the census was 142. The requirement at 42 CFR Subpart 483.90(a) is	K 000		

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

Electronically Signed | 03/09/2023

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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K 000	Continued From page 1 NOT MET as evidenced by:	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS	K 222		4/3/23

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K 222	Continued From page 2 Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interviews from 2/27/23 to 2/28/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that the 15-second delayed egress feature on 2 of 8 exit discharge doors (with this feature) observed would activate properly when tested in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.6.1. This deficient practice was evidenced by the following: 1. On 2/27/23 at 11:55 AM, the surveyor observed	K 222	1.How will corrective action be accomplished for those individuals□ residents citied for this deficiency? Contractor contacted by Maintenance Director on February 28, 2023 to coordinate and schedule repairs to Egress Doors near room #232 and room # 132. 2.How will we identify other resident who have potential to be affected by the same deficient Practice? All residents have the potential to be	

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K 222	Continued From page 3 that exit/egress door by Resident Room #232, when activated with the delayed 15-second egress feature, which was labeled with a sign that indicated, "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." This egress feature when activated did not function and the door remained locked. The MD stated the fire alarm would release the device if it was activated. 2. On 2/28/23 at 09:41 AM, the surveyor observed that exit/egress door by Resident Room #132, when activated with the delayed 15-second egress feature, which was labeled with a sign that indicated, "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." This egress feature when activated did not function and the door remained locked. The MD stated the fire alarm would release the device if it was activated. An interview was conducted with the MD during the above observations where he confirmed when he activated the delayed door feature on the above doors, they remained locked. The MD and Director of Nursing were notified of the findings at the Life Safety Code exit conference on 2/28/23. The Licensed Nursing Home Administrator was not in the building at this time. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.2.1.6.1.1(3)C	K 222	affected by this deficient practice. 3.What measure will be put in place or systemic changes made to ensure that the deficient practice does not recur? Maintenance Director or Designee will audit all Egress/Exit Doors in the entire center on a weekly basis for 4 weeks, Then monthly therefore after. 4.How will we monitor our Corrective action to ensure that the deficient practice is being corrected and not recur? Maintenance Director or Designee will provide results of data collected from audits at Monthly QAPI Meeting to ensure the deficient practice is corrected and will not recur.	
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	K 281		4/3/23

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K 281	Continued From page 4 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 interview from 2/27/23 to 2/28/23, in the presence of facility Maintenance Director (MD), 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 2 of 4 occupied access areas observed and was evidenced by the following: 1. On 2/27/23 at 11:41 AM, the surveyor in the presence of the MD, observed in the second-floor Ocean Unit occupied Resident Lounge by the Nurse's Station, that 4-wall switches shut-off all the ceiling lights. The room was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. 2. On 2/28/23 at 9:30 AM, the surveyor in the presence of the MD, observed in the first-floor Seashore Unit occupied Resident Lounge by the Nurse's Station, that 3-wall switches shut-off all 14-ceiling light fixtures. The room was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. The MD confirmed the finding at the time of observations. The MD and Director of Nursing were informed of these findings at the Life Safety Code survey exit	K 281	1.How will corrective action be accomplished for those individuals□ residents citied for this deficiency? Maintenance Director contacted electrician and scheduled work needed to repair Ocean Unit Day Room and Seashore Unit Day Room wall switches to ensure there will be enough illumination for means of egress continuously in operation. 2.How will we identify other resident who have potential to be affected by the same deficient Practice? All residents have the potential to be affected by this deficient practice. 3.What measure will be put in place or systemic changes made to ensure that the deficient practice does not recur? Maintenance Director of Designee will conduct a monthly audit for six months on common area rooms to insure there is illumination for means of egress continuously in operation. 4.How will we monitor our Corrective action to ensure that the deficient practice is being corrected and not recur?	

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K 281	Continued From page 5 conference on 2/28/23. The Licensed Nursing Home Administrator was not at the building at this time. 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	Maintenance Director or Designee will provide results of data collected from audits at Monthly QAPI Meeting to ensure the deficient practice is corrected and will not recur.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe	K 321		4/3/23

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K 321	Continued From page 6 Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 2/27/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was identified in 6 of 18 hazardous area storage room doors and was evidenced by the following: 1. On 2/27/23 at 12:08 PM, the surveyor observed the kitchen door had an auto closing device installed, but the door remained in the open position, due to a wooden chock (wedge) installed under the door. 2. On 2/27/23 at 12:14 PM, the surveyor observed the kitchen's dry-storage room door that had an auto-closing device installed, but the door was held open with a sling attached to shelving that would keep the door open in the event of a smoke/fire condition. No staff were in the general area of the observation. 3. On 2/27/23 at 12:20 PM, the surveyor observed the outer 90-minute door to the laundry room did not fully close into its frame. The door was hitting the top of the frame and did not latch. The MD confirmed the findings at the time of the observations.	K 321	1.How will corrective action be accomplished for those individuals□ residents citied for this deficiency? Maintenance Director removed wooden wedge immediately at the kitchen door along with the sling attached to a shelf in the kitchen□s dry storage room. Maintenance Director immediately repaired the door which was hitting the top of the frame leading into the laundry room. 2.How will we identify other resident who have potential to be affected by the same deficient Practice? All residents have the potential to be affected by this deficient practice. 3.What measure will be put in place or systemic changes made to ensure that the deficient practice does not recur? Maintenance Director or Designee will in-service all center staff on not to use anything that will prop any auto closing doors. Maintenance Director or Designee will conduct a weekly audit for 4 weeks to ensure compliance with this deficient practice, and monthly therefore after. 4.How will we monitor our Corrective action to ensure that the deficient practice	

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K 321	Continued From page 7 The MD and Director of Nursing were notified of the findings at the Life Safety exit conference on 2/28/23. The Licensed Nursing Home Administrator was not in the building at this time. NJAC 8:39-31.2 (e) Life Safety Code 101-2012 edition	K 321	is being corrected and not recur? Maintenance Director or Designee will provide results of data collected from audits at Monthly QAPI Meeting to ensure the deficient practice is corrected and will not recur.	
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 2/27/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to install supervised smoke/heat detection in accordance with NFPA 101, 2012 Edition, Section 19.3.4.1, 9.6.1.8, NFPA 70, 2011 Edition and NFPA 72, 2010 Edition. This deficient practice was observed in 1 of 1 kitchen areas and was	K 341	1.How will corrective action be accomplished for those individuals□ residents citied for this deficiency? Maintenance Director ordered parts on March 1, 2023 for kitchen supervised heating detection system to be installed by center Fire Safety Company	4/3/23

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K 341	Continued From page 8 evidenced by the following: On 2/27/23 at 12:08 PM, the surveyor and MD observed that the facility failed to provide supervised smoke/heat detection in the kitchen. The surveyor observed no evidence of a smoke/heat detector within 20-feet of the cooking system as required by code. The MD confirmed the finding during the kitchen observation. No further information was provided. The MD and Director of Nursing were notified of the finding at the Life Safety Code exit conference on 2/28/23. The Licensed Nursing Home Administrator was not in the building at this time. NJAC 8:39 -31.2 (a).	K 341	Contractor. 2.How will we identify other resident who have potential to be affected by the same deficient Practice? All residents have the potential to be affected by this deficient practice. 3.What measure will be put in place or systemic changes made to ensure that the deficient practice does not recur? Maintenance Director or Designee will coordinate to add kitchen heat detector to annual inspection conducted by our Fire Safety Company Contractor. 4.How will we monitor our Corrective action to ensure that the deficient practice is being corrected and not recur? Maintenance Director or Designee will provide results of data collected from Fire Safety Company Contractor report at Monthly QAPI Meeting to ensure the deficient practice is corrected and will not recur.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are	K 353		4/3/23

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K 353	Continued From page 9 maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on surveyor observation and interview on 2/27/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to maintain all parts of their automatic sprinkler system in optimal condition as per section 5.2.1.1.1 of National Fire Prevention Association (NFPA) 25. This deficient practice was identified for 6 of 6 exterior fire sprinkler heads and evidenced by the following: On 2/27/23 at 09:07 AM, the surveyor entered the facility and observed the exterior front entrance overhang. The combustible overhang was constructed to protect cars while loading and unloading passengers. The area was observed to have six fire sprinkler heads loaded with a heavy coating of green oxidation/corrosion. An interview was conducted with the MD during the observation, and he confirmed that the six exterior fire sprinkler heads protecting the combustible overhang had a heavy coating of green oxidation/corrosion. The MD and Director of Nursing were informed of	K 353	1.How will corrective action be accomplished for those individuals□ residents citied for this deficiency? Maintenance Director contacted Fire Safety Company Contractor to coordinate the replacement of the six exterior fire sprinkler heads located on the exterior overhang. 2.How will we identify other resident who have potential to be affected by the same deficient Practice? All residents have the potential to be affected by this deficient practice. 3.What measure will be put in place or systemic changes made to ensure that the deficient practice does not recur? Maintenance Director or Designee will audit all automatic fire sprinkler heads, both interior and exterior on a monthly basis for six month.	

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K 353	Continued From page 10 the finding at the Life Safety Code exit conference on 2/28/23. The Licensed Nursing Home Administrator was not in the building at this time. NJAC 8:39 - 31.1(c), 31.2(e) NFPA 13, 25	K 353	4. How will we monitor our Corrective action to ensure that the deficient practice is being corrected and not recur? Maintenance Director or Designee will provide results of data collected from audits at the Monthly QAPI Meeting to ensure the deficient practice is corrected and will not recur.	
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 2/28/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure resident bathroom ventilation systems were adequately maintained and operating in optimal condition, in accordance with the National Fire Protection Association (NFPA) 90 A, B and B). This deficient practice was identified for 14 of 38 resident room bathrooms vents observed and was evidenced by the following: 1. On 2/28/23, during a tour of the building, the surveyor with the MD, toured the facility and	K 521	1.How will corrective action be accomplished for those individuals□ residents citied for this deficiency? Maintenance Director immediately replaced the belts on the exhaust for resident bathrooms in rooms 119 to 131. 2.How will we identify other resident who have potential to be affected by the same deficient Practice? All residents have the potential to be	4/3/23

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JERSEY SHORE CENTER	**3 INDUSTRIAL WAY EAST** **EATONTOWN, NJ 07724**

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K 521	Continued From page 11 observed that the ventilation in the Seashore Unit, Resident Rooms 119 to 131 bathroom ventilation systems did not function when the MD applied a piece of single-ply toilet tissue paper across the ceiling grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. An interview was conducted with the MD during the observations, and he confirmed the findings. The MD stated the roof unit may have a bad motor and/or a broken fan belt He stated currently the facility did not have a ventilation inspection log or operating check list to provide. The MD and Director of Nursing were informed of the findings at the Life Safety Code exit conference on 2/28/23. The Licensed Nursing Home Administrator was not in the building at this time. NFPA 90 A NFPA 101-2012 -19.5.2.1 section 9.2.2 NFPA 101-2012- 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NJAC 8:39-31.2(e)	K 521	affected by this deficient practice. 3.What measure will be put in place or systemic changes made to ensure that the deficient practice does not recur? Maintenance Director or Designee will audit all resident bathroom's ventilation systems on a weekly for three months, then monthly therefore after to ensure compliance. 4.How will we monitor our Corrective action to ensure that the deficient practice is being corrected and not recur? Maintenance Director or Designee will provide audit results at monthly QAPI Meeting to ensure the deficient practice is corrected and will not recur.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted	K 712		4/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315364	A. BUILDING **01** B. WING _____	**02/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE CENTER	**3 INDUSTRIAL WAY EAST** **EATONTOWN, NJ 07724**

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K 712	Continued From page 12 between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documents on 2/27/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to conduct fire drills with varying activation types and simulation of specific emergency fire conditions in accordance with NFPA 101, 2012 Edition, Section 19.7.1.4 through 19.7.1.7. This deficient practice was identified for 12 of 12 fire drills and was evidenced by the following: On 2/27/23, the survey in the presence of the MD, reviewed the facility's fire drill reports which revealed the method for the simulation of emergency fire conditions were not varied and specific to location for 12 of 12 fire drills. The dates and type of alarm transmission: pull, smoke, or page was as follows: 3/17/22 Smoke-1st floor- 4/30/22 Heating unit failure-1st floor-page 5/31/22 Smoke-laundry-page 6/15/22 Smoke-Ocean wing-electrical 7/29/22 Smoke-lobby 8/16/22 Smoke- laundry-page 9/24/22 Electrical-2nd floor-heater 10/12/22 Smoke- 2nd floor 11/11/22 Smoke-Navesink wing-page 12/16/22 Smoke-1st floor Navesink wing room#2 1/31/23 Smoke-laundry dryer 2/20/23 Smoke-lobby-page An interview was conducted with the MD after	K 712	1.How will corrective action be accomplished for those individuals□ residents citied for this deficiency? Maintenance Director contacted Fire Drill Company on March 2, 2023 to discuss, review, and ensure that monthly center fire drills are conducted with varying activation types and simulation of specific emergency fire conditions. Maintenance Director contacted Fire Drill Company on March 2, 2023 to discuss, review, and ensure 2.How will we identify other resident who have potential to be affected by the same deficient Practice? All residents have the potential to be affected by this deficient practice. 3.What measure will be put in place or systemic changes made to ensure that the deficient practice does not recur? Maintenance Director or Designee will audit and review monthly center fire drills to ensure that they are varying drills and detailed in our fire drill report monthly for 3 months. 4.How will we monitor our Corrective action to ensure that the deficient practice	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315364	A. BUILDING **01** B. WING _____	**02/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 712	Continued From page 13 documentation review, and he confirmed the findings that currently fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions were not varied and specific to areas documented on the form. The MD and Director of Nursing were informed of the finding at the Life Safety Code exit conference on 2/28/23. The Licensed Nursing Home Administrator was not in the building at this time. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.7.1.4 through 19.7.1.7	K 712	is being corrected and not recur? Maintenance Director or Designee will provide audit results at monthly QAPI Meeting to ensure the deficient practice is corrected and will not recur.	

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
315364 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	4/4/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE CENTER	3 INDUSTRIAL WAY EAST EATONTOWN, NJ 07724

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		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0222	04/03/2023	LSC	K0281	04/03/2023	LSC	K0321	04/03/2023
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0341	04/03/2023	LSC	K0353	04/03/2023	LSC	K0521	04/03/2023
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0712	04/03/2023	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	
2/28/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO