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

PRINTED: 12/13/2022 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SIMULSTRIAL WAY EAST EACH OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SIMULSTRIAL WAY EAST EACH OF PROVIDER OR NOT PREFIX TAG PROVIDERS PLAN OF CORRECTION PREFIX TAG PROVIDERS PLAN OF CORRECTION PREFIX PROVIDERS PLAN OF CORRECTION PREFIX PROVIDERS PLAN OF CORRECTION SHOULD BE CARD OF CORRECTION OR SHOULD BE CARD OR SHOULD BE CA	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
JERSEY SHORE CENTER JERSEY SHORE CENTER JINDUSTRIAL WAY EAST EATONTOWN, NJ 07724 REGULATORY OR LSO IDENTIFYING INFORMATION) FOUND INITIAL COMMENTS COMPLAINT #: NJ 00137680, NJ 00137652 CENSUS: 128 SAMPLE SIZE: 6 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANT WISTER PRECUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLIANT VISIT. F 6009 F609 F60			315364	B. WING				
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS COMPLAINT #: NJ 00137680, NJ 00137652 CENSUS: 128 SAMPLE SIZE: 6 THE FACILITY IS NOT IN SUBSTANTIAL COMPLAINT WIST. COMPLAINT WIST. F 609 FF609 Seporting of Alleged Violations COMPLAINT VISIT. F 609 S42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. F 609 S43.12(c)(1) (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 if the events that cause the allegation involve abuse or 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					3 INDUSTRIAL WAY EAST	1 03	711/2020	
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	1486-1	investigations to the	e administrator or his or her				000 5 : 75	

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

(X6) DATE

Electronically Signed

09/23/2020

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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OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	315364	B. WING		_ 0	C 9/11/2020	
NAME OF PROVIDER OR SUPPLIER JERSEY SHORE CENTER			3 INDUSTRIAL WAY EAST	TE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
designated represe accordance with St Survey Agency, wit incident, and if the appropriate correction This REQUIREMENT by: Complaint #: NJ00 Based on interview pertinent facility do that the facility faile Department of Hearincident of unknown results of the investifive (5) working day This deficient practified (5) working day This deficient practified (5) working day This deficient practified (5) working day The Surveyor review Resident #4. Review of the admit Resident #4 was according to the admit Resident #4 was	ntative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced 137680 , record review, and review of cuments, it was determined d to a.) notify the New Jersey lith (NJDOH) of an injury norigin and b.) report the tigation to the NJDOH within vs of the incident. Ice was identified for Resident is reviewed for an unwitnessed hout injury and was evidenced wed the medical record for sident's esthat included but were not he record could not lise the resident sident was not present in the rivey.	F 6	F= 609 SS=D Reporting of Alleged 1. How will correcti accomplished for the residents cited on the for resident #4 Ombudsman on 9/2 investigation was column and Legal Guardian. The patient received sent to the hospital for upon discovery of occurred on 7/11/20 2. How will we iden who have potential for practice? All residents with injurate the potential for practice. 3. What measures	ve action be pose individual to deficiency? ent practice, the process of the pro	nt t	
the resident had an	incident on		systemic changes m	ade to ensure that		
	PROVIDER OR SUPPLIER SHORE CENTER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa designated represe accordance with St Survey Agency, wit incident, and if the a appropriate correcti This REQUIREMEN by: Complaint #: NJ00 Based on interview pertinent facility do that the facility faile Department of Hea incident of unknown results of the invest five (5) working day This deficient practi #4, 1 of 2 residents accident with or wit by the following: The Surveyor review Resident #4. Review of the admi Resident #4. Review of the admi Resident #4 was accomply the surveyor review Resident #4. Review of the admi Resident #4 was accomply the following: The Surveyor review Resident #4 was accomply the following: The Surveyor review Resident #4 was accomply the following: The Surveyor review Resident #4 was accomply the following: The Surveyor review Resident #4 was accomply the following: The Surveyor review Resident #4 was accomply the following: The Surveyor review Resident #4 was accomply the following: The Surveyor review Review of the admi Resident #4 was accomply the following: The Review of the admi Resident #4 was accomply the following: The Review of the admi Resident #4 was accomply the following: Review of the elections accomply the following the fol	SHORE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 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: Complaint #: NJ00137680 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to a.) notify the New Jersey Department of Health (NJDOH) of an injury incident of unknown origin and b.) report the results of the investigation to the NJDOH within five (5) working days of the incident. This deficient practice was identified for Resident #4, 1 of 2 residents reviewed for an unwitnessed accident with or without injury and was evidenced by the following: The Surveyor reviewed the medical record for Resident #4. Review of the admission record indicated that Resident #4 was admitted to the facility in with diagnoses that included but were not limited to:	A BUILDI 315364 B. WING 31536 B. WINC 31566 B. WINC 31566 B. WINC 31566 B. WING 31566 B. WINC 315	ROVIDER OR SUPPLIER SHORE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 1 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 RECUIREMENT is not met as evidenced by: Complaint #: NJ00137680 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to a.) notify the New Jersey Department of Health (NJDOH) of an injury incident of unknown origin and b.) report the results of the investigation to the NJDOH within five (5) working days of the incident. 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Review of the electronic progress notes indicated 3 INDUSTRIAL WAY EAST EATONTOWN, NJ 07724 \$ IRPOVIDERS NJAN OF CORRECTION (EACH CATON SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPORTED TO THE APPROPRIATE DEPORTED TO THE APPROPRIATE DEPORTED TO THE APPROPRIATE DEPORTED TO THE APPROPRIATE AND PROVIDED TO THE APP	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315364	B. WING		C 09/11/2020	1
NAME OF PROVIDER OR SUPPLIER JERSEY SHORE CENTER			;	STREET ADDRESS, CITY, STATE, ZIP CODE 3 INDUSTRIAL WAY EAST EATONTOWN, NJ 07724		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLÉTION	1
F 609	The resident was evided was evided what happened due Doctor notified and resident to hospital The resident was treatment township first aid. On 09/11/2020 at 1 interviewed the Direct asked what the facing resident sustained at The DON replied and started and the Derwould be notified of investigation. The stated that she remincident. She stated done; however, she the DOH. Review of the facility Accidents/Incident, that notification of smade" Review of the facility Abuse Prohibition," report findings of all	ected the following: the wed walking in the hallway. A to the ent, along with the scorted back to his/her room ministered. Were ent was NJ Exec. Order 26:4.b.1 were ent was NJ Exec. Order 26:4.b.1 to to Excorder to the Medical orders received to send for evaluation and treatment. ansported to the hospital by ector of Nursing (DON) and lity's process would be if a an injury of unknown origin. In investigation would be partment of Health (DOH)	F 609	the deficient practice does not re-order will re-educate all staff on the policy and procedure of reporting it of unknown origin. We will immediate report all injuries of unknown origin DOH and Ombudsman as required investigation will follow and be sensed above agencies with a summary aconclusion of what occurred. 4. How will we monitor our correspondence is being corrected and will re-occur? Incidents/Accidents will be reviewed by the Administrator/DON/Designed ensure any residents with an injury unknown origin is reported immediathe DOH and Ombudsman as requal An investigation including a summa conclusion will be completed and such the DOH and Ombudsman within it days of the incident. The center wand trend compliance via monthly 3 months and then reevaluate.	he njuries ately n to the d. An at to the nd ctive a l not ed daily se to y of fately to uired. ary and sent to five fill track	

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		315364	B. WING		no	C 0/11/2020		
	AME OF PROVIDER OR SUPPLIER ERSEY SHORE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODI 3 INDUSTRIAL WAY EAST EATONTOWN, NJ 07724		09/11/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE		
F 609	•	ate on-line reporting system or ns.	F6	609				

POST-CERTIFICATION REVISIT REPORT									
PROVIDER / SUPPLIER IDENTIFICATION NUMBER 315364		STRUCTION				Vo.	DATE 0	F REVISIT	
NAME OF FACILITY JERSEY SHORE CEN		STREET ADDRESS, CITY, STATE, ZIP CODE 3 INDUSTRIAL WAY EAST EATONTOWN, NJ 07724					Y3		
program, to show those corrected and the date	d by a qualified State sue deficiencies previously such corrective action vhe identification prefix c	reported on the vas accomplishe	CMS-2567, Statemed. Each deficiency s	ent of Deficie hould be ful	encies and Plan ly identified usin	of Corrections of Corrections	on, that h regulati	nave been on or LSC	
ITEM Y4	DATE Y5	ITEM Y4		DATE Y5	ITEM Y4			DATE Y5	
ID Prefix F0609	Correction	ID Prefix		Correction	ID Prefix			Correction	
Reg. # 483.12(c)(1)(4) LSC	Completed 09/28/2020	Reg. #	C	Completed	Reg. #			Completed	
ID Prefix	Correction	ID Prefix		Correction	ID Prefix			Correction	
Reg. #	Completed	Reg.#	C	Completed	Reg. #			Completed	
ID Prefix	Correction	ID Prefix	C	Correction	ID Prefix			Correction	
Reg. # LSC	Completed	Reg. #	C	Completed	Reg. #			Completed	
ID Prefix	Correction	ID Prefix	(Correction	ID Prefix			Correction	
Reg. #	Completed	Reg. #	C	Completed	Reg. #			Completed	
ID Prefix	Correction	ID Prefix		Correction	ID Prefix			Correction	
Reg. #	Completed	Reg. #	0	Completed	Reg.#			Completed	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SU	IRVEYOR			DATE		
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE				DATE		

9/11/2020

FOLLOWUP TO SURVEY COMPLETED ON

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

☐ YES ☐ NO