STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. BUILDING _____ B. WING _____	C 05/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER CREEK NURSING AND REHABILITATION CENTER	**524 WARDELL ROAD TINTON FALLS, NJ 07753**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS C #: NJ00139474 Census: 52 Sample Size: 3 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		6/1/21

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

Electronically Signed | 05/13/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 656	Continued From page 1 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: C #: NJ00139474 Based on interviews, and record review, as well as review of pertinent facility documents on 5/10/21, it was determined that the facility failed to ensure the Resident's Care Plan was consistently implemented for 1 of 3 residents (Res #1). This deficient practice is evidenced by the following: 1. According to the "ADMISSION RECORD" Res #1 was initially admitted to the facility on [redacted], with diagnoses that included but were not limited to: *Ex Order 26. 4B1* [redacted]. The Minimum Date Set (MDS), an assessment	F 656	Criteria 1 The facility will establish, maintain, and follow a Comprehensive Care Plan that is person-centered to maintain resident's medical, nursing, mental and psychosocial needs that are identified in their assessment. Care Plan for all residents will be followed as documented. Resident Care Plan will be followed as stated, in order to provide a safe sanitary and comfortable environment in the monitoring of resident #1 in the prevention of Ex.Order 26.4(b)(1) . Staff were educated on the monitoring of resident #1 regarding history of Ex.Order 26.4(b)(1) . Nursing staff will be checking resident #1's room for hand-sanitizer on a daily basis. All staff within the facility is on alert to report any	

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F 656	Continued From page 2 tool dated 3/20/21, showed that the Resident was Ex Order 26. 4B1 with Activities of Daily Living (ADL). The Facility Reportable Event (FRE) dated Ex Order 26. 4B1 showed that on Ex Order 26. 4B1 at 2:30 pm, Res #1 was on the facility's patio, Ex.Order 26.4(b)(1) . Res #1 was escorted back to his/her room. Inside the Resident's room, staff observed a nearly empty bottle of hand sanitizer. Res #1 admitted that he/she Ex.Order 26.4(b)(1) . The facility called 911. The 911 paramedics arrived and transferred Res #1 to the Ex.Order 26.4(b)(1) for evaluation. Attached with the FRE, the "Investigative Summary" which showed that the Resident returned to the facility on Ex Order 26. 4B1. The facility's investigative conclusion showed alcohol based substance would be secured in a locked area when not in use and to check the Resident's room twice a shift and ongoing. Attached with the FRE, Res #1's Focus Care Plan (FCP) initiated on 10/7/15, revised on 4/2/20, showed that Res #1 had Ex Order 26. 4B1 related to Ex Order 26. 4B1 . The FCP further showed that Res #1 had a history of Ex Order 26. 4B1 . Intervention included but was not limited to; Check Resident's room daily to ensure no hand sanitizer. The same FCP was revised on 9/11/20. Intervention included but was not limited to: Check the Resident's room twice a shift to ensure no hand sanitizer. The form titled "[Res #1] ROOM TO BE CHECKED TWICE A SHIFT FOR HAND SANITIZER" showed no documentation to	F 656	incident of residents #1 consuming hand-sanitizer within the facility environment. Staff will be on alert for Resident #1 if Ex.Order 2 tries to Ex.Order 26.4(b)(1) from the hand-sanitizer machines dispensers located throughout the facility. Criteria 2 All residents with a history of ETOH have the potential of being affected by this cited deficiency. A review was done by the IDC team for all residents with a history of ETOH, and their Care Plan was up-dated as needed. The IDCP team including Social Worker, MDS Coordinator, Rehab, Recreation, Supervisor and Director of Nursing will continued to up date all residents Care Plan assuring that they are being follow. Criteria 3 A review was done on all residents care plans to ensure that all interventions are still applicable and are being followed. Nursing staff have been in-serviced to ensure that all care plan interventions are followed. Staff have been in-serviced to ensure that all hand sanitizer bottles including the bottles kept on the medication carts are always secured and kept out of residents reach and that the hand sanitizer dispensers that are mounted throughout the facility are mounted properly to ensure that they cannot be removed by the residents. Criteria 4 The DON or designee will audit random resident's charts to ensure that all care plan interventions are being followed. This	

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F 656	Continued From page 3 indicate that the Resident's room was checked twice a shift (7:00-3:00 pm, 3:00 pm-11:00 pm and 11:00 pm-7:00 am) to ensure no hand sanitizer which was not according to the FCP as follows: On 10/23/20 through 10/31/20 and for the months of 12/2020, 1/2021, 2/2021, and 3/2021. The "Progress Notes (PN)" for the aforementioned dates did not indicate that Res #1's room was checked twice a shift to ensure no hand sanitizer. During an interview with the Certified Nursing Assistant (CNA) and License Practical Nurse (LPN), assigned to Res #1 on 5/10/21 at 9:48 am and 9:56 am, stated that they did not know that Res #1's room had to be checked for hand sanitizer twice a shift. During an interview with the Nurse Supervisor (NS) on 5/10/21 at 12:54 pm, she stated that nurses assigned to Res #1 were responsible to check the Resident's room to ensure no hand sanitizer and should document it on the aforementioned form. The NS stated that documentation was important to indicate that the room was checked as care planned. During an interview with the Director of Nursing DON on 5/10/21 at 12:33 pm, stated that she was not aware of the Resident's aforementioned FCP intervention until last April of 2021. The policy titled "Residents/Patients Care Plans" dated 12/2020 revised on 2/2021, showed under "Procedure...4. Care Plans are dynamic ongoing process...9. All Care Plan issues or problems are to be identified on an ongoing basis...Care Plans	F 656	audit will be done on 4 residents weekly for 4 weeks then monthly for 3 months. The DON or designee will ensure on daily rounds that all hand sanitizer is safely secured throughout the facility. The results of these audits will be shared with the Quality Assurance team which will make further recommendations based on the results of these audits.	

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F 656	Continued From page 4 are the working document of the care of the resident/patient in reaching their potential goal..." NJAC 8:39-11.2 (f)	F 656		

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
315414 Y1	A. Building B. Wing Y2	6/4/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER CREEK NURSING AND REHABILITATION CENTER	524 WARDELL ROAD TINTON FALLS, NJ 07753

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0656 Reg. # 483.21(b)(1) LSC	Correction Completed 06/01/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 5/10/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			