STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	C 03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	**101 WALNUT STREET NEPTUNE, NJ 07753**

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F 000	INITIAL COMMENTS Complaint #: NJ177301 Survey Date: 2/27/25 to 3/5/25 Census: 88 Sample: 18+3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		4/11/25

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

Electronically Signed | 03/24/2025

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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain a individualized comprehensive care plan (ICCP) that included interventions that were specific to a resident identified as having a [redacted] This deficient practice was identified for 1 of 18 residents reviewed (Residents #46), and was evidenced by the following: A review of the Admission Record face sheet (admission summary) indicated that Resident #46 was admitted to the facility with diagnoses which included but was not limited to; [redacted]	F 656	F656 Annual Survey 2025 Compliance Date: April 11, 2025 How the corrective action will be accomplished for those residents found to be affected by this practice? Affecting Resident #46 [redacted] care plan was immediately updated for Resident #46. The nurses were in-serviced by the Director of Nursing on maintaining an individualized comprehensive care plan, that includes interventions that are specific to the resident when identified as having a [redacted]	

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F 656	Continued From page 2 NJ Exec Order 26.4b1 A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 2, reflected that Resident #46 was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 with activities of daily living (ADLs). The MDS also indicated that the resident had a NJ Exec Order 26.4b1 On 2/27/25 at 10:47 AM, during tour, the surveyor observed Resident #46 in the facility NJ Exec O wearing NJ Exec Order 26.4b1 on both NJ Exec Orde The resident was NJ Exec O and NJ Exec Order 26.4b and had NJ Exec Order 26.4b1. On 3/3/25 at 9:50 AM, the surveyor interviewed Resident #46's US FOIA (b)(6)), who stated that the resident was NJ Exec O and NJ Exec Order 26.4b and was able to NJ Exec Order 26.4b1 . The US FOIA (b stated that the resident required NJ Ex Order 26.4b1 for their ADLs and was NJ Ex Order 26.4b1 . The US FOIA (b explained that the resident wore some sort of NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1, however, he did not know why. The US FOIA (b stated that the nurses applied the NJ Exec Order 26.4b1 On 3/3/25 at 9:00 AM, the surveyor interviewed Resident #46, who stated that they usually wore NJ Exec Order 26.4b1 on their NJ Exec Order 26.4b1 that were applied by the NJ Exec Order 26 care center every Wednesday. The resident explained that the facility applied NJ Exec Order 26.4b1 on their NJ Exec Orde and that the facility nurses provided NJ Exec Order 2 care to the NJ Exec Order 26.4b and applied the NJ Exec Order 26.4b on Saturday. The resident NJ Exec Order 26.4b1	F 656	How the Facility will identify other residents having the potential to be affected by the same deficient practice? All Residents have the ability to be affected by the facility not meeting the requirements of maintaining an individualized comprehensive care plan for residents identified as having a diabetic ulcer. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? The Nurse Supervisors and Nurses were in-serviced by the Director of Nursing on maintaining an individualized comprehensive care plan (ICCP) that includes interventions that are specific to the resident when identified as having a diabetic ulcer. The Nurse Supervisors or designees will audit the residents identified as having a diabetic ulcer, and an individualized comprehensive care plan to ensure it includes interventions that are specific to the resident; weekly x4, monthly x 3 months, and quarterly thereafter. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?) The Nurse Supervisors/designee will review any findings of these audits and present them quarterly with the Quality	

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F 656	Continued From page 3 and stated that the [NJ Exec Order 2] on the [NJ Exec Order 26.4b] was [NJ Exec Order 26.4b1]. On 3/3/25 at 9:54 AM, the surveyor interviewed the[US FOIA (b)(6)]), who stated that the resident had a treatment order to apply [NJ Exec Order 26] on their [NJ Exec Order 26.4b] and a [NJ Exec Order 26.4b] on their [NJ Exec Order 26.4b] ([NJ Exec Order 26.4b1]) three times a week. The [US FOIA] stated that it was important to include any pertinent information regarding treatments, [NJ Exec Order 26.4b] and preventative care on the resident's ICCP because the ICCP provided information about the resident and how to care for the resident. The surveyor reviewed the physician's order summary which revealed the following treatment orders: A review of the physician's order (PO) dated [NJ Exec Order 2], for [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1]; must have [NJ Exec Order 26.4b1] and change [NJ Exec Order 26.4] every two hours. The resident may [NJ Exec Order 26.4b1] with a [NJ Exec Order 2] assist every shift for [NJ Exec Order 26] care. A review of the PO dated [NJ Exec Order 26.4b], indicated that the nurse was to apply [NJ Exec Order 26] three times weekly every day shift on Tuesday, Thursday, and Saturday for [NJ Exec Order 26.4b1]. A review of PO dated [NJ Exec Order 26], reflected an order to [NJ Exec Order 26.4b1] with [NJ Exec Order 26.4b1]; apply [NJ Exec Order 26.4b1] and [NJ Exec Ord] with [NJ Exec Order 26.4b1]) every day shift on Tuesday, Thursday, and Saturday. A review of Resident #46's ICCP included a focus	F 656	Assurance and Performance Improvement committee to determine the frequency of future audits.	

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F 656	Continued From page 4 area for [NJ Exec O] alteration ICCP, but did not include that the resident wore [NJ Exec Order 26.4b1], or that the resident was provided with [NJ Exec Order 2] care to the [NJ Exec Order 26.4b]. On 3/3/25 at 10:08 AM, the surveyor interviewed the [US FOIA] who explained that the resident wore the [NJ Exec Order 26.] to the [NJ Exec Order 26.4b1] three times weekly. The [US FOIA] also stated that Resident #46 had a [NJ Exec Order 26] to the [NJ Exec Order 26.4b] and that a treatment to their [NJ Exec Order 26.4b1]; [NJ Exec Order 26.4b1] the [NJ Exec Order 2] with [NJ Exec Orde] application of [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b] the [NJ Exec Order 26] with an [NJ Exec Order 26.4b1] on Tuesday, Thursday, and Saturday. The [US FOIA] reviewed the resident's ICCP in the presence of the surveyor, and could not explain why the treatments were not documented in the ICCP. On 3/4/25 at 9:57 AM, the surveyor interviewed the [US FOIA (b)(6)], who explained that the resident's ICCP was resident specific and provided a detailed account on how to take care that resident. The [US FOIA (b)(6)] stated that it was important to update the ICCP with an accurate record to include current [NJ Exec Order 26.] and [NJ Exec Order 26.4] that have [NJ Ex Order 26.4b] The [US FOIA (b)(6)] continued to explain that it was also important to include preventative [NJ Exec Order 26.4b1] to prevent further development of [NJ Exec Order 26.4] and to [NJ Exec O] existing [NJ Exec Order 26.4b] The [US FOIA (b)(6)] stated that the ICCP should be an accurate account of what was going on with that resident and acknowledged that Resident #46's ICCP was not updated to include interventions and treatments related to their [NJ Exec Order 26.4b1]. On 3/4/25 at 12:43 PM, the surveyor interviewed the [US FOIA (b)(6)], who acknowledged that Resident #46's ICCP should	F 656		

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F 656	Continued From page 5 have been updated with accurate [NJ Exec Order 26] care interventions. The [US FOIA (b)] stated that the ICCP should include what kind of care the resident was receiving and the nurses followed the ICCP. The [US FOIA (b)] explained that any new interventions or changes in care were documented on the ICCP. A review of the facility's undated "Care Plans-Comprehensive" policy included that the residents ICCP would reflect treatment goals and revised as changes in the resident's condition dictate...	F 656		
F 658 SS=E	NJAC 8:39-11.2(e) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, review of the clinical records and pertinent facility documentation, it was determined that the facility to a.) ensure the documentation for the administration of [NJ Exec Order 2] treatments for 1 of 2 residents (Resident #46) reviewed for [NJ Exec Order 26.4b] b.) properly secure medications during medication administration observation, and c.) ensure the medication cart was locked when not in use for 1 of 4 medication carts ([NJ Ex Order 26.4b1]) in accordance with professional standards of practice. Reference: New Jersey Statutes, Title 45,	F 658	F658 Annual Survey 2025 Compliance Date: April 11, 2025 How the corrective action will be accomplished for those residents found to be affected by this practice? Affecting Resident #46. [NJ Exec Order 26] Treatment administration documentation was reviewed and updated immediately to reflect the physician order. All Nurses were in-serviced by the Director of Nursing on ensuring proper transcription of wound orders to the residents treatment administration record.	4/11/25

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F 658	Continued From page 6 Chapter 11, Nursing Board, The Nurse Practice Act for the state of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist:" Reference New Jersey Statutes, Title 45, Chapter 11, Nursing Board, The Nurse Practice Act for the state of New Jersey states; "The practice of nursing as a licensed practical nurse is defined as performing task and responsibilities within the framework of case finding; reinforcing the patient family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the duration of a registered nurse or licensed or otherwise legally authorized physician or dentist." This deficient practice was evidenced by the following: 1. A review of the Admission Record face sheet (admission summary) indicated that Resident #46 was admitted to the facility with the diagnoses which included but was not limited to; NJ Exec Order 26. [redacted]. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 2, reflected that Resident #46 was NJ Exec Order 26.4b1 and required NJ Exec Order 26.4b1 with activities of daily living (ADLs). The MDS	F 658	Medications were removed and secured and the cart was locked immediately. 1:1 in-service was done for the nurse involved in this deficient practice by the Director of Nursing. How the Facility will identify other residents having the potential to be affected by the same deficient practice? All Residents have the ability to be affected by the facility not meeting the requirements of ensuring proper transcription of wound orders to the residents treatment administration record. All Residents have the ability to be affected by the facility not meeting the requirements of ensuring the medication cart is locked when not in use and medications left unsecured during medication administration. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? All Nurses and supervisors were in-serviced by the Director of Nursing on ensuring proper transcription of wound orders to the residents treatment administration record. The Nurse Supervisors or designees will audit the residents identified as having wounds, to ensure proper transcription of wound orders to the residents treatment administration record; weekly x4, monthly x 3 months, and quarterly thereafter. The Nurses were in-serviced by the Director of Nursing on locking medication carts when not in use and securing all medications during medication	

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F 658	Continued From page 7 indicated that the resident had a [redacted] On 2/27/25 at 10:47 AM, during tour, the surveyor observed Resident #46 in the facility [redacted] wearing [redacted] to both [redacted]. The resident was [redacted] and [redacted] and had [redacted] On 3/3/25 at 9:50 AM, the surveyor interviewed Resident #46's [redacted]), who stated that the resident was [redacted] an [redacted] and was able to [redacted]. The [redacted] stated that the resident required [redacted] care with their ADLs and was [redacted]. The [redacted] explained that the resident wore some sort of [redacted] on the [redacted], however, did not know why. The [redacted] stated that the nurses applied the [redacted] On 3/3/25 at 9:00 AM, the surveyor interviewed Resident #46, who stated that they usually [redacted] to their [redacted] that were applied by the [redacted] care center every Wednesday. The resident explained that the facility applied [redacted] to their [redacted] and that the facility nurses provided [redacted] care to the [redacted] on Saturday. The resident [redacted] and stated that the [redacted] on the [redacted] was slowly [redacted] A review of the [redacted] Care Center Report ([redacted] dated [redacted] reflected that Resident #46 had a [redacted] to their [redacted] with the [redacted]	F 658	administration. The Nurse Supervisors or Designee will audit the medication carts being locked when not in use and for and that no medications are left unsecured during medication administration; weekly x4, monthly x3, and quarterly thereafter. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?) The Nurse Supervisors/designee will review any findings of these audits and present them quarterly with the Quality Assurance and Performance Improvement committee to determine the frequency of future audits.	

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F 658		F 658		

Continued From page 8

NJ Exec Order 26.4b1 The measurements were NJ Exec Order 26.4b1 with a small amount of NJ Exec Order 26.4b1 that was NJ Exec Order 2 in color and NJ Exec Order 26.4b amount of NJ Exec Order 26.4b1

A review of the NJ Exec Order 26 dated NJ Exec Order 26.4 , indicated that Resident #46 had a NJ Exec Order 26.4b1 related NJ Exec Order 26 but NJ Exec Order 26.4b1 to their NJ Exec Order 26.4b and NJ Exec Order 26.4b with the NJ Exec Order 26.4b1. The measurements of the NJ Exec Order 26 were smaller at NJ Exec The NJ Ex Order 26.4b had no NJ Exec Order 26.4b with some NJ Exec Order 26.4b1) with a NJ Exec Order 26.4b amount of NJ Exec Order 26.

A review of the NJ Exec Order 26 dated NJ Exec Order 26.4b indicated that Resident #46 had a NJ Exec Order 26.4b1 related NJ Exec Order 26.4b1 and NJ Exec Order 26.4b with the NJ Exec Order 26.4b1. The NJ Exec Order 26 continued to have NJ Exec Order 26.4b1 with NJ Exec Order 26.4b amount of NJ Exec Order 26. The treatment orders had changed at that time.

On 3/3/25 at 9:54 AM, the surveyor interviewed the US FOIA (b)(6) who stated that the resident had a treatment order to apply NJ Exec Order 26.4b to their NJ Exec Order 26.4b and NJ Exec Order 26.4b to the NJ Exec Order 26.4b three times a week. The US FOIA stated that when she received the treatment order, the order was transcribed onto the Treatment Administration Record (TAR) and then the nurse signed the TAR when the treatment was complete.

The surveyor reviewed the physician's order

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F 658	Continued From page 9 summary which revealed the following treatment orders: A review of the physician's order (PO) dated [redacted] for NJ Exec Order 26.4b1 [redacted] and change [redacted] every two hours. The resident may bear [redacted] with a walker assist every shift for [redacted] care. A review of the PO dated [redacted], indicated that the nurse was to apply [redacted] three times weekly every day shift on Tuesday, Thursday, and Saturday for NJ Exec Order 26.4b1. A review of PO dated [redacted] reflected an order to NJ Exec Order 26.4b1 [redacted]; and [redacted] with NJ Exec Order 26.4b1 [redacted]) every day shift on Tuesday, Thursday, and Saturday. A review of Resident #46's TAR did not include the treatment orders for the NJ Exec Order 26.4b1 [redacted] The treatment orders were not transcribed onto the TAR. There were no signatures from the nursing staff that indicated that these treatments were being administered, however the resident indicated that treatments were being provided and the [redacted] documentation indicated that the [redacted] was smaller and improving. On 3/3/25 at 10:08 AM, the surveyor interviewed the [redacted] who explained that the resident wore the [redacted] to NJ Exec Order 26.4b1 [redacted] three times weekly. The [redacted] also stated that Resident #46 had a [redacted] to the [redacted] and that a treatment to the NJ Exec Order 26.4b1; NJ Exec Order 26.4b1 [redacted], and	F 658		

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F 658	Continued From page 10 NJ Exec Order 26.4b the NJ Exec Order 26 with an NJ Exec Order 26.4b1 on Tuesday, Thursday, and Saturday. The US FOIA reviewed the TAR in the presence of the surveyor and could not explain why the treatments were not documented on the TAR. The US FOIA stated that she was the assigned nurse that performed the treatments and she knew that they were completed. The US FOIA acknowledged that the treatment orders were not transcribed onto the TAR as ordered by the physician and there were no nurses' signatures that indicated that the treatments were performed. On 3/3/25 at 10:18 AM, the surveyor interviewed the US FOIA (b)(6) who stated that she was responsible to complete NJ Exec Order 26 reports on the weekends and explained that she was not sure why the treatments orders were not transcribed onto the TAR and she would have to review the resident's medical record. The US FO stated that after she reviewed the resident's medical record, she would get back to the surveyor. On 3/3/25 at 11:14 AM, the surveyor interviewed the US FO who stated that that the RN who took the treatment order from the physician on NJ Exec Order 26, for the NJ Exec Order 26 and treatment for the NJ Exec Order 26.4b did not put the order in the electronic medical record (EMR) correctly resulting in the treatments not being transcribed over to the TAR. The US FO stated that the US FOIA performed the treatment on Saturday NJ Exec Order 2, however the US FOIA did not give the US FO an explanation as to why she did not sign the treatment orders. The US FO stated that if the US FOIA signed the TAR after she completed the resident's NJ Exec Order 2 care, that she would have identified that the treatment was not transcribed	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	C 03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 658	Continued From page 11	F 658		

onto the TAR. The [US FOIA (b)(6)] reviewed the treatment order dated 2/5/25, for [NJ Exec Order 26.4b1] every shift for [NJ Exec Order 2] care and confirmed that the order was also not transcribed to the TAR since that date even though the [NJ Exec Order 26.4b1] were in place as ordered. The [US FOIA (b)(6)] stated that the [NJ Exec Order 26] care was provided as ordered, however it was a transcription error that occurred in the EMR.

On 3/4/25 at 9:57 AM, the surveyor interviewed the [US FOIA (b)(6)], who explained that when a nurse took a physician's order, the nurse had to make sure the order was transcribed to either to the Medication Administration Record (MAR) or the TAR. The [US FOIA (b)(6)] stated that it was important to assure proper transcription of the order so that there were no medication errors and to assure that a treatment or medication was provided to the resident. The [US FOIA (b)(6)] stated that he had reviewed Resident #46's treatment orders and confirmed that the [US FOIA] had an error in documentation and did not transcribe the treatment orders to the resident's TAR. The [US FOIA (b)(6)] stated that the [US FOIA] that took the orders had performed the treatments, but she did not sign that the treatments were performed on the TAR.

On 3/4/25 at 12:43 PM, the surveyor interviewed the [US FOIA (b)(6)] who stated that she expected the nursing staff to transcribe the treatment orders to the correct location on the TAR so that the order could be followed and completed.

On 3/5/25 10:22 AM, the [US FOIA (b)] stated that the 2/5/25, the order for the [NJ Exec Order 26.4b1] was written incorrectly with no specification for monitoring, however the [NJ Exec Order 26.4b1] were not to be removed

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	**101 WALNUT STREET NEPTUNE, NJ 07753**

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F 658	Continued From page 12 and were to be monitored for placement every shift. The [US FOIA (b)] also stated that the PO for the [NJ Exec Order 26.4b1] was also not transcribed correctly and should have been written specifically to include the location, time, and removal of the boots. The [US FOIA (b)] stated that the treatment orders dated [NJ Exec Order 26.4b], should have been transcribed to the TAR and that the [US FOIA] had made a transcription error. The [US FOIA (b)] stated that the same [US FOIA] took the PO on NJ Exec Order 26.4b1, and confirmed that the orders should have been reviewed during the 24-hour chart check to assure that the orders were complete, accurate, written and transcribed onto the TAR. A review of the facility's "Orders" policy dated 12/2024, included that a verbally communicated order must contain all components of a valid written order... a RN or Licensed Practical Nurse (LPN) can accept and transcribe verbal or telephone orders and that the process for accepting verbally communicated orders was that the listener would transcribe the order to the electronic medical record and under the resident's chart... A review of the facility's "24 Hour Chart Check" policy dated 9/2024, included that the facility would review medical records every 24 hours to identify any physician's orders that require processing or further attention... the facility would validate that orders were transcribed correctly onto the MAR and TAR and if any discrepancies were noted, corrections would be made... 2. On 2/27/25 at 9:23 AM, the surveyor observed the US FOIA (b)(6)) leave a bottle of acidophilus with pectin 100 capsules on top on the medication cart unattended and the	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	C 03/05/2025

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F 658	Continued From page 13 medication cart was left unlocked, while the nurse obtained vital signs on a resident. There were no residents present by the cart at that time. On 2/27/25 at 9:41 AM, the surveyor observed the [US FOIA (b)] leave a bottle of eye drops on the top of the medication cart unattended, while administering medications to a resident. There were no residents present by the cart at that time. On 2/27/25 at 9:52 AM, the surveyor interviewed the [US FOIA (b)] who stated that the medication cart could be left unlocked and unattended as long as it was up against the room doorway. The [US FOIA (b)] stated that the medications should not be left on top of the medication cart unattended. In addition, the [US FOIA (b)] acknowledged that the acidophilus and eye drops were left on top of the medication cart unattended. On 2/28/25 at 1:00 PM, the surveyor interviewed the [US FOIA (b)(6)] who confirmed that the nurse should not have left the acidophilus and eyes drops on top of the medication cart unattended. The [US FOIA (b)] stated that a nurse could not leave medications unattended and should not turn their back with medications on top to the medication cart. The [US FOIA (b)] confirmed that medication carts should be locked when unattended. A review of the facility's "Medication Administration" policy dated reviewed 10/2024 included:...7. No medications on top of cart. 8. Medication cart locked when not in use... NJAC 8:39-27.1(a); 29.4(h)	F 658		

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
	061304	A. BUILDING: _____ B. WING _____	C 03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATIC	101 WALNUT STREET NEPTUNE, NJ 07753

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S 000	Initial Comments Complaint #: NJ177301 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 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 177301 Based on interview and review of pertinent facility documents, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for 4 out of 21 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	S 560	S560 Annual Survey 2023 Compliance Date: April 11, 2025 How the corrective action will be accomplished for those residents found to be affected by this practice? Confirmed with the recruiter that all ads were optimized to the fullest to properly staff the facility in accordance with NJ regulations. How the Facility will identify other residents having the potential to be affected by the same	4/11/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 03/24/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061304	A. BUILDING: _____ B. WING _____	C 03/05/2025

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S 560	Continued From page 1 with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 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. 1. For the week of complaint staffing from 5/19/24 to 5/25/24, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: 5/19/24 had 9 CNAs for 89 residents on the day shift, required at least 11 CNAs. 5/22/24 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs. 2. For the two weeks of staffing prior to survey from 2/9/25 to 2/22/25, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: 2/9/25 had 9 CNAs for 84 residents on the day	S 560	deficient practice? All residents have the potential to be affected by the facility not meeting the requirements to maintain the required minimum direct care staff-to-resident ratios, as mandated by the State of New Jersey. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? Administrator rein–serviced staffing coordinator regarding proper staffing ratios. Recruitment efforts are in place to assist the facility in recruiting Certified Nursing Aides. Efforts include; receiving a sign on bonus, referral bonus, and reimbursement for Certified Nursing Aide tuition. The facility also contracted with agencies to recruit Certified Nursing Aides. The Director of Nursing/designee will audit direct care staffing ratios to ensure it is meeting the requirements as mandated by the State of New Jersey; weekly x 4, monthly x 3, and quarterly thereafter. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?) The administrator /designee will review any findings of these audits and present them quarterly with the Quality Assurance and Performance Improvement committee to determine the frequency of future audits.	

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S 560	Continued From page 2 shift, required at least 10 CNAs. 2/15/25 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs. On 3/4/25 at 9:46 AM, the surveyor interviewed the Staffing Coordinator (SC) staff member. The SC was able to recite the CNA ratios based on the regulations for minimum required staff. The SC stated that she made the schedules ahead of time to ensure the facility had the proper ratios. The SC further stated that the facility utilized agencies to fill open time slots. The SC also stated that the facility used incentives such as sign-on bonuses and bonuses when staff picked up additional shifts. A review of the facility's "Staffing" policy with a reviewed date of 8/2024, included ...It is the policy and procedure of this facility to adequately staff the facility in accordance with the NJ State guidelines ...1. The staffing coordinator along with the Director of Nursing and the Administrator will staff the building based on the census and acuity of the building. a. In accordance with the NJ Staffing Ratio requirements: Day Shift - 1:8 (CNA to resident), Evening shift - 1:10 (Direct care staff to resident), Night shift - 1:14 (Direct care staff to resident). 2. Should there be a need, the facility will mitigate any staffing openings with agency staff. 3. The facility will maintain sufficient agency contracts to meet their staffing needs. 4. The facility will utilize sign on bonuses for new staff and referral bonuses for staff ...	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315056 Y1	A. Building B. Wing Y2	4/17/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, 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	Correction	ID Prefix F0658	Correction	ID Prefix	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. #	Completed
LSC	04/11/2025	LSC	04/11/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/5/2025	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061304 Y1	A. Building B. Wing Y2	4/17/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/11/2025	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	
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	
3/5/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061304 Y1	A. Building B. Wing Y2	4/17/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/11/2025	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	
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	
3/5/2025	☐ 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
	315056	A. BUILDING **01** B. WING _____	**03/05/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	**101 WALNUT STREET** **NEPTUNE, NJ 07753**

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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		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 2/28/25 and 3/3/25 and the facility was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Jersey Shore Post Acute Rehabilitation and Nursing is a one story building constructed in 1954 with an addition on the Star unit in 1965. There are 2 partial basements and 7 smoke zones. The facility has a 60 kilowatt diesel fueled generator. The facility has 105 licensed beds occupying 88 at the time of survey.	K 000		
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface.	K 271		4/11/25

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

Electronically Signed | 03/24/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING 01 B. WING _____	03/05/2025

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JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, 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
K 271	Continued From page 1 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 3/3/25 in the presence of the [redacted]), it was determined the facility failed to maintain a stable, level walking surface at exit discharge for 1 of 5 exterior exits observed in accordance with NFPA 101:2012 Edition, Section 7.7, 7.1.6.2, 7.1.10.1 and 19.2.7. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations at 11:08 AM revealed that the corridor exterior exit by room number 12 exit discharge path to a public way posed a trip hazard in the path of egress for evacuation. Where the sidewalk met the curb at the parking lot edge, the concrete curb was deteriorated. The deteriorated depression was 8-1/2 inches wide and ran across the width of the sidewalk. There was an 1-1/4 inch lip at the end of the side walk and the deteriorated concrete rubble was loose. In an interview at the time, the [redacted] confirmed the observations. The facility's [redacted] were informed of the deficient practice during the Life Safety Code exit conference at 1:49 PM. NJAC 8:39-31.2(e)	K 271	K271 Annual Survey 2025 Compliance Date: April 11, 2025 How the corrective action will be accomplished for those residents found to be affected by this practice? Affecting all residents, the exit discharge containing a deterioration was fixed to be back in accordance with NFPA 101:2012 Edition Section 7.7, 7.1.6.2, 7.1.10.1 and 19.2.7. How the Facility will identify other residents having the potential to be affected by the same deficient practice? All Residents have the ability to be affected by the facility not meeting the requirements of a stable, level walking surface at exit discharge for exterior exits. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? The exterior exit located by room number 12, area has been repaired by placing fresh concrete in order to maintain a stable, level walking surface exit discharge for exterior exits. The [redacted] was rein-serviced by the Administrator on maintaining a stable, level walking surface exit discharge for exterior exits. The Maintenance Director or designee will audit exterior exits, exit discharges for deterioration; monthly x 3 months, quarterly thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING **01** B. WING _____	**03/05/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	**101 WALNUT STREET** **NEPTUNE, NJ 07753**

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K 271	Continued From page 2	K 271	How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?) The Maintenance Director /designee will review any findings of these audits with the Administrator and present them quarterly with the Quality Assurance and Performance Improvement committee to determine the frequency of future audits.	
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 3/3/25 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that exits were marked by an approved sign that is readily visible, and that a sign with directional indicator showing the direction of travel was provided in every location where the direction of travel to reach the nearest exit is not apparent in accordance with NFPA 101:2012 Edition, Sections 19.2.10.1, 7.10, and 7.10.1.2.1. This deficient practice had the	K 293	K293 Annual Survey 2025 Compliance Date:Aprill 11, 2025 How the corrective action will be accomplished for those residents found to be affected by this practice? Affecting all residents. Exit signs leading out of the large enclosed courtyard and small enclosed courtyard were installed. How the Facility will identify other residents having the potential to be affected by the same	4/11/25

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	315056	A. BUILDING 01 B. WING _____	03/05/2025

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K 293	Continued From page 3 potential to affect all residents and was evidenced by the following: An observation at 11:32 AM revealed the facility failed to provide approved exit signs leading out of the large, enclosed courtyard. An observation at 12:10 PM revealed the facility failed to provide approved exit signs leading out of the small, enclosed courtyard. In an interview at the times, the US FOIA (b)(6) confirmed the observations. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference at 1:49 PM. N.J.A.C 8:39-31.2(e)	K 293	deficient practice? All Residents have the ability to be affected by the facility not meeting the requirements of ensuring that exits are marked by an approved sign that is readily visible, and that a sign with directional indicator showing the direction of travel is provided. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? Approved exit signs in the large, enclosed courtyard and small, enclosed courtyard were installed to ensure a sign with directional indicator showing the direction of travel is provided. The US FOIA (b)(6) was rein-serviced by the administrator on the requirements of ensuring that exits were marked by an approved sign that is readily visible, and that a sign with directional indicator showing the direction of travel is provided. The Maintenance Director / Designee will audit all locations where the direction of travel to reach the nearest exit is not apparent in order to ensure that exits are marked by an approved sign that is readily visible, and that a sign with a directional indicator showing the direction of travel is provided; monthly x3 , quarterly thereafter. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?)	

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K 293	Continued From page 4	K 293	The Maintenance Director /designee will review any findings of these audits with the Administrator and present them quarterly with the Quality Assurance and Performance Improvement committee to determine the frequency of future audits.	
K 353 SS=F	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 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 observations and interviews on 3/3/25 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that sprinkler heads had their escutcheons installed and were orientated in their proper place in accordance	K 353	K353 Annual Survey 2025 Compliance Date: April 11, 2025 How the corrective action will be accomplished for those residents found to be affected by this practice? Affecting all residents. Escutcheon was	4/11/25

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K 353	Continued From page 5 with NFPA 13:2010 Edition and NFPA 25: 2011 Edition, Sections 5.2.1.1.1 to 5.2.1.1.4, 5.2.3.2 and 5.4.1.8. This deficient practice had the potential to affect all residents and was evidenced by the following: 1. An observation of resident room 31 at 10:33 AM revealed the escutcheon plate was missing on 1 of the 2 sprinkler heads. 2. An observation of the kitchen storage closet at 10:49 AM revealed the escutcheon plate was coming down 1-inch from its proper place in the drop ceiling. 3. An observation of the oxygen room at 11:05 AM revealed the escutcheon plate was coming down 1-inch from its proper place in the drop ceiling. 3. An observation of the Medication room at 11:26 AM revealed the sprinkler escutcheon plate was coming down 1-inch from its proper place in the drop ceiling. 4. An observation of the soiled utility room across from the conference room at 11:39 AM revealed a sprinkler escutcheon plate was coming down 1-inch from its proper place in the drop ceiling. 5. An observation of the TV room closet at 12:15 revealed the sprinkler pipe was extruding down through the drop ceiling 4-3/4 inches to the sprinkler head. The sprinkler head is designed to be orientated in the plane of the drop ceiling. In interviews at the times, the US FOIA (b)(6) confirmed the observations.	K 353	placed on the sprinkler head that was missing one. For the escutcheons and sprinkler head that were not oriented in their proper place, the sprinkler company was called down to complete necessary repairs Pictures will be uploaded on EPOC upon completion of repairs. How the Facility will identify other residents having the potential to be affected by the same deficient practice? All Residents have the ability to be affected by the facility not meeting the requirements of sprinkler heads and their escutcheons installed and orientated in the proper place. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? The sprinkler head found to be missing the escutcheon, had the escutcheon installed. The sprinkler head and escutcheons found not oriented properly in their place, will be repaired to ensure the proper placement. The US FOIA (b)(6) rein-serviced by the Administrator on ensuring that sprinkler heads have their escutcheons installed and oriented in the proper place. The Maintenance Director will audit to ensure that sprinkler heads have their escutcheons installed and oriented in the proper place; monthly x3 months , quarterly thereafter. How the facility will monitor its corrective	

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K 353	Continued From page 6 The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference at 1:49 PM. NJAC 8:39-31.2(e) NFPA 13, 25	K 353	actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?) The Maintenance Director /designee will review any findings of these audits with the Administrator and present them quarterly with the Quality Assurance and Performance Improvement committee to determine the frequency of future audits.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other	K 363		4/11/25

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K 363	Continued From page 7 materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 3/3/25 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that corridor doors maintain a clearance between the bottom of the door and the floor covering not exceeding 1-inch in accordance with NFPA 101:2012 Edition, Sections 19.3.6.3.4. This deficient practice had the potential to affect 6 of 88 residents and was evidenced by the following: An observation at 10:21 AM of resident room number 40 revealed the corridor door had a 1-3/4 inch space between the bottom of the door and the floor covering. An observation at 10:25 AM of resident room number 37 revealed the corridor door had a 1-1/4 inch space between the bottom of the door and the floor covering. An observation at 10:26 AM of the medication room revealed the corridor door had a 1-1/2 inch space between the bottom of the door and the	K 363	K363 Annual Survey 2025 Compliance Date:April 11, 2025 How the corrective action will be accomplished for those residents found to be affected by this practice? Affecting 6 residents in room 40, 37 and medication room. The corridor doors were repaired to ensure that they maintain a clearance between the bottom of the door and the floor covering not exceeding 1-inch, in accordance with NFPA 101:2012 Edition, Sections 19.3.6.3.4. How the Facility will identify other residents having the potential to be affected by the same deficient practice? All Residents have the ability to be affected by the facility not meeting the requirements of ensuring that corridor doors maintain a clearance between the bottom of the door and the floor covering not exceeding 1-inch. What measures will be put in place or what systemic changes will be made to	

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K 363	Continued From page 8 floor covering. In interviews at the times, the[redacted] confirmed the observations. The facility's[redacted] was informed of the deficient practice at the Life Safety Code exit conference at 1:49 PM. NJAC 8:39-31.2(e)	K 363	ensure that the deficient practice will not recur? The corridor doors were repaired to ensure the door maintains a clearance between the bottom of the door and the floor covering does not exceed 1-inch. The[redacted] was rein-serviced by the Administrator on the requirement of corridor doors maintaining a clearance between the bottom of the door and the floor covering not exceeding 1-inch. The Maintenance Director will audit corridor doors to ensure they maintain a clearance between the bottom of the door and the floor that does not exceed 1-inch ; monthly x 3 months ; quarterly thereafter. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?) The Maintenance Director /designee will review any findings of these audits with the Administrator and present them quarterly with the Quality Assurance and Performance Improvement committee to determine the frequency of future audits.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid	K 374		4/11/25

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K 374	Continued From page 9 bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/3/25 in the presence of the US FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation in accordance with NFPA 101:2012 Edition, Sections 19.3.7.8 and 8.5.4.1. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:26 AM revealed the center hall smoke barrier door had space between the latching edge of the door and the door frame where light was visibly passing through. The space between the door and door frame measured 1/2-inch on the lobby side and 5/8-inch on the opposite side and ran 32-inches from the bottom of the door up to the door handle. In interview at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit	K 374	K374 Annual Survey 2025 Compliance Date: April 11, 2025 How the corrective action will be accomplished for those residents found to be affected by this practice? Affecting all residents. The center hall smoke barrier door was repaired to ensure that no gap is present beyond the minimum clearance necessary for proper operation in accordance with NFPA 101:2012 Edition, Sections 19.3.7.8 and 8.5.4.1. How the Facility will identify other residents having the potential to be affected by the same deficient practice? All Residents have the ability to be affected by the facility not meeting the requirements of ensuring doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not	

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K 374	Continued From page 10 conference at 1:49 PM. NJAC 8:39-31.2(e)	K 374	recur? The center hall smoke barrier door was repaired to ensure that no gap is present beyond the minimum clearance necessary for proper operation. The US FOIA (b)(6) was rein-serviced by the Administrator on ensuring doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation. The Maintenance Director will audit all doors in smoke barriers to ensure the doors shall close the opening, leaving only the minimum clearance necessary for proper operation; monthly x3, quarterly thereafter. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?) The Maintenance Director /designee will review any findings of these audits with the Administrator and present them quarterly with the Quality Assurance and Performance Improvement committee to determine the frequency of future audits.	

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
315056 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	4/17/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0271	04/11/2025	LSC K0293	04/11/2025	LSC K0353	04/11/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0363	04/11/2025	LSC K0374	04/11/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/5/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO