New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _		С	
		YMOSFX	B. WING		1	5/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
MAGNOLIA GARDENS 1935 LAKEV TOMS RIVER						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
A 000	Initial Comments		A 000			
	Initial Comments: Survey: Focused Infe Census: 93	ction Control				
	Sample: 3					
	conducted by the Sta The facility was found with the New Jersey A infection control regul Licensure of Assisted	Living Residences, onal Care Homes and ams and Centers for Prevention (CDC)				
A 310	8:36-3.4(a)(1) Admini	stration	A 310			
	(a) The administrator responsible for, but no	or designee shall be ot limited to, the following:				
	1. Ensuring the dimplementation, and dand procedures,	levelopment, enforcement of all policies including resident rights;				

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

TITLE

(X6) DATE

08/09/24

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SI COMPLE		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1935 LAKEWOOD ROAD TOMS RIVER, NJ 08755 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1935 LAKEWOOD ROAD TOMS RIVER, NJ 08755 ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLET TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DATE					A. BOILDING.				
MAGNOLIA GARDENS 1935 LAKEWOOD ROAD TOMS RIVER, NJ 08755 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 1935 LAKEWOOD ROAD TOMS RIVER, NJ 08755 ID PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DATE				YMOSFX	B. WING				
MAGNOLIA GARDENS TOMS RIVER, NJ 08755 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TOMS RIVER, NJ 08755 ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLET TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	AME OF PROVIDER OR SUPPLIER	AME OF PF	IE OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)	IAGNOLIA GARDENS	IAGNOLI	GNOLIA GARDENS						
A 210 Continued From your 4	PREFIX (EACH DEFICIEN	PREFIX	REFIX (EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	COMPLETE	
This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the Executive Director (ED) failed to develop, implement, and enforce a policy and procedure to ensure housekeeping staff followed proper cleaning procedures to reduce potential cross-contamination of the resident's environment in response to an Interview of the following: On 7/15/2024 at 9:30 a.m., the surveyor interviewed the facility's Infection Control Preventionist (ICP) who stated that there were cases in the facility. At 12:26 p.m., the surveyor observed housekeeper (HK) #1 in the hallway with a cleaning cart and a yellow mop bucket, which contained a large string mop head with a handle. The surveyor interviewed the HK, who stated that when the residents' rooms were cleaned, the mop head and water were changed between every two rooms. At 12:34 p.m., the surveyor interviewed HK #2, who indicated that the mop head and mop water should be changed after every two to three rooms were cleaned. HK #2 further stated that microfiber mop heads were used in resident bathroom was cleaned. At 12:42 p.m., the surveyor interviewed the HK Director, who stated that housekeeping staff used string mops to clean resident thousekeeping staff used string mops to clean resident tooms, and the mop water and mop head were changed every two to three rooms.	This REQUIREMEN by: Based on interview a documents, it was d Director (ED) failed enforce a policy and housekeeping staff for procedures to reduce cross-contamination environment in respond This defiby the following: On 7/15/2024 at 9:3 interviewed the facily Preventionist (ICP) of the contained a large structure when the residents' head and water were rooms. At 12:34 p.m., the structure who indicated that the should be changed a were cleaned. HK ## microfiber mop head bathrooms only and bathroom was cleaned at 12:42 p.m., the structure who indicated that the should be changed a were cleaned. HK ## microfiber mop head bathrooms only and bathroom was cleaned at 12:42 p.m., the structure water and mop head	A 310	This REQUIREMENT by: Based on interview a documents, it was de Director (ED) failed to enforce a policy and housekeeping staff for procedures to reduce cross-contamination environment in responsible to the following: On 7/15/2024 at 9:30 interviewed the facility Preventionist (ICP) was cass At 12:26 p.m., the sure housekeeper (HK) #* cleaning cart and a y contained a large strict The surveyor interview when the residents' r	and review of pertinent facility etermined that the Executive to develop, implement, and procedure to ensure collowed proper cleaning to potential of the resident's conse to an exercise of the resident's conse to an exercise of the facility. In the surveyor ty's Infection Control who stated that there were ease in the facility. In the hallway with a reliance were determined between every two the trooms were cleaned, the mop to changed between every two three rooms to further stated that is were used in resident changed after each ed. In the veryor interviewed the HK that housekeeping staff used resident rooms, and the mop were changed every two to	A 310				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:				
		YMOSFX	B. WING		07/	/15/2024		
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE				
MAGNOL	IA GARDENS		KEWOOD ROAD IVER, NJ 08755					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	PROVIDER'S PLAN OF CORRECTION (X5 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5 COMPL DAT			
A 310	used to clean the floo bathrooms only, and a were changed after e The surveyor reviewe "Housekeeping Policy date of 5/9/2024, that Resident rooms Do every four (4) rooms.' At 1:30 p.m., the surv facility's ICP, who sta heads should be used changed after each ro The facility general he comprehensive and d that mirrored the ICPs disinfection during an	crofiber mop heads were or in the residents' the microfiber mop heads ach room. ed a facility policy titled, y- General", with a revised indicated, "Procedures 2. not forget to change water" reyor interviewed the ted that microfiber mop d in resident rooms and	A 310					
A1185	(b) Housekeeping per cleaning procedures, of equipment. This REQUIREMENT by: Based on observation pertinent facility docu	rsonnel shall be trained in including the use and care is not met as evidenced in, interview, and review of ments, it was determined sekeeping failed to follow	A1185					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S		
			A. BUILDING: _				
		YMOSFX	B. WING		07/1	, 5/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
MAGNOLI	A GARDENS	1935 LAK	EWOOD ROAD				
MAGNOL	AGARDENO	TOMS RIV	/ER, NJ 08755				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE	
A1185	Continued From page	e 3	A1185				
	proper cleaning procedures to reduce the potential for cross-contamination of the resident's environment during an NJ ex order 26.4b1 This deficient practice was evidenced by the following: On 7/15/2024 at 9:30 a.m., the surveyor interviewed the facility's Infection Control Preventionist (ICP), who stated that there were cases in the facility. At 12:26 p.m., the surveyor observed housekeeper (HK) #1 in the hallway with a cleaning cart and a yellow bucket, which contained a large string mop head with a handle. The surveyor interviewed the HK, who stated that when the residents' rooms were cleaned, the mop						
	rooms. At 12:34 p.m., the su who indicated that the should be changed a were cleaned. Contin	•					
	Director, who stated string mop heads to on the mop water and movery two to three roon Director confirmed the were used to clean the bathrooms only, and were changed after each of the string of the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			, 20.22o.		С			
		YMOSFX	B. WING		07/15/2024			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
MAGNOLI	A GARDENS		EWOOD ROAD ER, NJ 08755					
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A1185	1 0	d in resident rooms and	A1185					
ı								

STATE FORM: REVISIT REPORT											
	R / SUPPLIER / CL		MULTIPLE CONS	TRUCTION						DATE O	F REVISIT
IDENTIFICATION NUMBER YMOSFX A. Building B. Wing									Y2	8/22/20	24 _{Y3}
NAME OF FACILITY							STREET ADDRESS, CIT	Y, STATE, ZIP	CODE		
MAGNOL	IA GARDENS					- 1	1935 LAKEWOOD ROAI				
							TOMS RIVER, NJ 08755	i			
corrective	action was acco	omplished	d. Each deficien	cy should be	fully ident	ified usin	reported that have bee g either the regulation s shown to the left of e	or LSC provis	ion number and	the	
ITEM	Л		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	A0310		Correction	ID Prefix	A1185		Correction	ID Prefix			Correction
Reg.#	8:36-3.4(a)(1)		Completed	Reg. #	8:36-17.2(b	p)	Completed	Reg. #			Completed
LSC			08/08/2024	LSC			08/08/2024	LSC			·
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
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REVIEWED	ЭВҮ	REVIEW (INITIAL:		DATE	Т	ITLE				DATE	

Page 1 of 1 EVENT ID: RWFP12

YES NO

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

7/15/2024

FOLLOWUP TO SURVEY COMPLETED ON