

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

PRINTED: 07/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/14/2025
NAME OF PROVIDER OR SUPPLIER ATLANTIC COAST REHAB & HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 485 RIVER AVE LAKEWOOD, NJ 08701		
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F 000	INITIAL COMMENTS Complaint #: NJ 168136, 171968, 176439 Survey Date: 2/18/2025 Census: 140 Sample: 28 +3 The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550			4/1/25

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

TITLE

(X6) DATE

Electronically Signed

03/10/2025

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 550	<p>Continued From page 1</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure a resident was transported from one area of the unit to another in a dignified manner for 1 of 29 sampled residents, (Resident #109). This deficient practice was evidenced by the following:</p> <p>On 02/10/2025 at 10:39 AM, the surveyor observed the U.S. FOIA (b) (6) transport a resident (Resident #109) NJ Ex Order 26.4(b)(1) in his/her NJ Ex Order 26.4(b)(1) from the resident hallway to the nurse station.</p> <p>According to the Admission Record Resident #109 was admitted to the facility with diagnoses including but not limited to: NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)</p> <p>A review of the most recent Minimum Data Set (MDS) an assessment tool used to facilitate care</p>	F 550	<p>S550 D Resident Rights/Exercise of Rights</p> <p>1. Resident #109 was evaluated by the Unit Manager and determined to have NJ Ex from being transported backwards in their NJ Ex Order 26.4(b)(1) chair from one area of the unit to another.</p> <p>2. Residents who utilize geriatric chairs had the potential to be affected. The Director of Nursing conducted an audit of residents utilizing geriatric chairs and observed that all residents were transported in a manner that showed courtesy, consideration, respect and dignity. No other residents were affected by this deficient practice.</p> <p>3. The identified aide was re-educated immediately upon notification of this finding on how to properly transport residents in geriatric chairs to maintain</p>		

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F 550	<p>Continued From page 2</p> <p>dated ^{NJ Ex Order 26.4(b)(1)}, revealed that Resident #109 had ^{NJ Ex Order 26.4(b)(1)}. The MDS further indicated that the resident required ^{NJ Ex Order 26.4(b)(1)} activities of daily living.</p> <p>During an interview with the surveyor on 02/10/2025 at 10:41 AM, the ^{U.S. FOIA (b) (6)} said that ^{NJ Ex Order 26.4(b)(1)} a resident ^{NJ Ex Order 26.4(b)(1)} should be avoided for safety reasons, as the resident would likely find it ^{NJ Ex Order 26.4(b)(1)} and ^{NJ Ex Order 26.4(b)(1)}.</p> <p>During an interview with the surveyor on 02/10/2025 at 10:51 AM, the ^{U.S. FOIA (b) (6)} stated that residents should be ^{NJ Ex Order 26.4(b)(1)} all the time to keep the resident from getting ^{NJ Ex Order 26.4(b)(1)}.</p> <p>During an interview with the surveyor on 02/14/25 at 10:02 AM, the ^{U.S. FOIA (b) (6)} stated there was no policy regarding transporting however he stated, "absolutely not", when asked if a resident should be ^{NJ Ex Order 26.4(b)(1)}.</p> <p>The surveyor reviewed the facility provided Resident Rights which reflected that the residents were to be treated with courtesy, consideration, and respect for your dignity and individuality.</p> <p>The surveyor reviewed the facility provided job description for a Certified Nursing Assistant which reflected that a. Respect for the patient/resident is consistently provided.</p> <p>NJAC 8:39-4.1(a)(12) Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)</p>	F 550	<p>their dignity and resident rights. The Assistant Director of Nursing provided re-education to the licensed and certified nursing staff as well as recreation and housekeeping staff on how to properly transport residents in geriatric chairs to maintain their dignity and resident rights. The facility's Resident Rights list was reviewed by the Administrator and Director of Social Services and determined that no changes needed to be made to the list at this time.</p> <p>4. The Director of Nursing or Assistant Director of Nursing will conduct weekly audits to observe how staff are transporting residents in geriatric chairs for 4 weeks, then monthly x 3 months to ensure that staff continue to transport residents in a manner that upholds their resident rights and dignity. Any untoward findings will be corrected immediately. The results of these audits and observations will be presented and reviewed at the Quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and to evaluate the need for further monitoring.</p>		
F 656 SS=D		F 656			4/1/25

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F 656	Continued From page 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 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	F 656			

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F 656	<p>Continued From page 4</p> <p>plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan that identified furnished services to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being for a resident that required [REDACTED] medications [REDACTED] and [REDACTED] for 2 of 28 residents reviewed for care planning (Resident # 89 and 96). This deficient practice was evidenced by the following:</p> <p>1. Upon initial tour of the facility on 2/10/2025 at 10:20 AM, surveyor #1 observed [REDACTED] standing upright on a [REDACTED] located to the right of Resident #89 on the bedside table. The [REDACTED] was not [REDACTED] and [REDACTED] the environment. Resident #89 was [REDACTED] and did not respond to surveyor #1's prompting.</p> <p>The surveyor reviewed the medical record for Resident #89.</p> <p>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: [REDACTED]</p>	F 656	<p>S656 D Development/Implement Comprehensive Care Plans</p> <p>1. The [REDACTED] and [REDACTED] were discarded for Resident #89 and a new set was dated and bagged for use. The care plan for Resident #89 was updated to reflect the use of the [REDACTED] Resident #89 had [REDACTED] from this deficient practice.</p> <p>Orders for the [REDACTED] for Resident #96 were clarified and the [REDACTED] was added to this resident's plan of care. Resident #96 had no negative effects from this deficient practice.</p> <p>2. Residents with care plans had the potential to be affected. The Director of Nursing conducted an audit of residents utilizing nebulizers and found no other residents affected by this deficient practice.</p> <p>3. The Director of Nursing conducted an audit of residents utilizing ankle foot orthosis devices for appropriate physician orders and care plans. No other residents were identified as affected by this practice.</p> <p>The Assistant Director of Nursing provided re-education to the Unit Managers and licensed nursing staff on the baseline care plan policy including when to update the</p>		

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F 656	<p>Continued From page 5</p> <p>NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1)</p> <p>A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4(b)(1) included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26.4(b)(1) out of 15, which indicated the resident's NJ Ex Order 26.4(b)(1) as NJ Ex Order 26.4(b)(1)</p> <p>A review of the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) Medication Administration Treatment included the following physician orders (PO):</p> <p>A PO, with a start date NJ Ex Order 26.4(b)(1), for NJ Ex Order 26.4(b)(1) four times a day for NJ Ex Order 26.4(b)(1)</p> <p>A review of Resident #89's care plan did not reveal a focus area identifying NJ Ex Order 26.4(b)(1) use.</p> <p>On NJ Ex Order 26.4(b)(1) at 12:31 PM, surveyor #1 interviewed Unit Manager Licensed Nurse Practitioner (UMLPN #1) who stated that they were not sure if NJ Ex Order 26.4(b)(1) treatments should be identified on the care plan.</p> <p>On 2/12/2025 at 12:43 PM, surveyor #1 interviewed UMLPN #2 who confirmed that NJ Ex Order 26.4(b)(1) treatments should be identified on the care plan. Upon reviewing Resident #89's care plan with surveyor #1, the UMLPN#2 was not able to locate NJ Ex Order 26.4(b)(1) treatments. UMLPN #2 stated that they will update Resident #89's care</p>	F 656	<p>plan of care when assistive devices and respiratory treatments are added.</p> <p>The Assistant Director of Nursing provided re-education to licensed and certified nursing staff on the facility's Splint and Brace Application Policy and Procedure. The facility's Admission and Baseline Care Plan policy was reviewed by the Director of Nursing and Regional Nurse Consultant. It was determined that no changes needed to be made to the policy at this time.</p> <p>The facility's Splint and Brace Application Policy and Procedure was reviewed by the Director of Nursing and Assistant Director of Nursing. It was determined that no changes needed to be made to the policy.</p> <p>4. The Director of Nursing or designee will conduct weekly audits x 4 weeks, then monthly audits x 3 months to assure that residents who receive nebulizer treatments are care planned. Any untoward findings will be corrected immediately.</p> <p>The Director of Nursing or designee will conduct weekly audits x 4 weeks, then monthly audits x 3 months to assure that residents with ankle foot orthosis devices are care planned and have a current physician order for the device is in the electronic medical record. Any untoward findings will be corrected immediately.</p> <p>The results of these audits and observations will be presented and reviewed at the Quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and to evaluate the need for further monitoring.</p>		

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F 656	<p>Continued From page 6 plan.</p> <p>On 2/12/2025 at 1:47 PM, surveyor #1 interviewed the [REDACTED] U.S. FOIA (b) (6), in the presence of the [REDACTED] U.S. FOIA (b) (6) and [REDACTED] U.S. FOIA (b) (6) in Training, who confirmed that [REDACTED] NJ Ex Order 26.4(b)(1) treatments should have been on Resident #89's plan of care.</p> <p>A review of the facility's "Admission and Baseline Care Plan (BCP)" Policy, last reviewed 3/5/2024, included: 1. [...] This initial plan of care also serves as the BCP for the resident. I) This initial baseline plan of care will address the immediate needs of the resident including, but not limited to: safety, personal hygiene, dietary needs, medications [...] 3. The BCP will be used as the foundation for care planning with additions/revisions being incorporated into the comprehensive care plan. Once the comprehensive care plan as been developed and implemented, any additional changes will be made to the comprehensive care plan based on the needs of the residents.</p> <p>N.J.A.C. 8:39-11.2 (e)</p> <p>On 02/10/2025 at 10:48 AM, Surveyor #2 observed Resident #96 wheeling [REDACTED] NJ Ex Order 26.4(b)(1) in a wheelchair [REDACTED] NJ Ex Order 26.4(b)(1) on [REDACTED] NJ Ex Order 26.4(b)(1)</p> <p>On 02/11/2025 at 10:00 AM, Surveyor #2 reviewed the electronic medical records (EMR) for Resident #96 as follows:</p>	F 656			

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F 656	<p>Continued From page 7</p> <p>According to the Admission Record Resident #96 was admitted to the facility with diagnoses including, but not limited to, [REDACTED].</p> <p>A review of Resident #96 most recent comprehensive Minimum Data Set (MDS) (an assessment tool used to facilitate the management of care) dated [REDACTED], revealed under section [REDACTED], that the resident had a Brief Interview for Mental Status (BIMS) (tool used to assess [REDACTED] in individuals) score of [REDACTED] out of 15, indicating the resident's [REDACTED].</p> <p>A review of the Admission Observation Assessment dated [REDACTED], indicated that Resident #96 was admitted with [REDACTED].</p> <p>A review of Resident #96 Care Plan did not address or include specific instructions for the care of [REDACTED] on his/her [REDACTED].</p> <p>A review of Resident #96 Physician Orders did not include current or discontinued orders for a [REDACTED] on his/her [REDACTED].</p> <p>During an interview with Surveyor #2 on 02/12/2025 at 1:12 PM, the Licensed Practical Nurse Unit Manager (LPNUM #1) said that there should have been an order in place, and it should have been included in the care plan when the resident was [REDACTED].</p> <p>During an interview with Surveyor #2 on 02/12/2025 at 1:23 PM, Resident #96 said that he/she had been [REDACTED] to</p>	F 656			

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F 656	<p>Continued From page 8</p> <p>his/her [NJ Ex Order 26.4(b)(1)] prior to admission to the facility and that he/she wore it every day except when he/she was in the bed. He/she also mentioned that he/she [NJ Ex Order 26.4(b)(1)].</p> <p>During an interview with Surveyor #2 on 02/13/2025 at 10:35 AM, the [U.S. FOIA (b) (6)] said that she notifies the [U.S. FOIA (b) (6)] and the [U.S. FOIA (b) (6)] to ensure that residents who [NJ Ex Order 26.4(b)(1)] or [NJ Ex Order 26.4(b)(1)] have an order and a care plan in place for the [NJ Ex Order 26.4(b)(1)].</p> <p>A review of the facility provided policy, with a review date of 03/05/2024, titled, "Admission and Baseline Care Plan (BCP)" revealed under the section titled "Procedure" that, "This initial baseline plan of care will address the immediate needs of the resident including, but not limited to: 1. (a) safety, (b) personal hygiene, (c) dietary needs, (d) medications, and (e) ambulation. 3. The BCP will be used as the foundation for care planning with additions/revisions being incorporated into the comprehensive care plan. Once the comprehensive care plan has been developed and implemented, any additional changes will be made to the comprehensive care plan based on the needs of the resident."</p> <p>A review of the facility provided policy, with a review date of 07/12/2024, titled, "Splint and Brace Application Policy and Procedure" revealed under the section titled "Procedure" that, "OT will evaluate patient for need for splinting, hand roll, or etc. Request an MD order as indicted. Explain procedure to the patient and tell patient to report any adverse effects. Position the patient comfortably. Check patient's skin for decreased sensation, wounds etc. Apply splint, hand roll etc.</p>	F 656			

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F 656	Continued From page 9 as per orders."	F 656			
F 690 SS=D	<p>N.J.A.C. 8:39-11.2 (e) Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)</p> <p>§483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.</p> <p>§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to</p>	F 690			4/1/25

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F 690	<p>Continued From page 10</p> <p>restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide treatment and care, based upon current standards of practice specifically by having a NJ Ex Order 26.4(b)(1) in contact with the floor, not documenting NJ Ex Order 26.4(b)(1), and not providing a NJ Ex Order 26.4(b)(1) 2 of 3 residents (Resident # 89, 100) reviewed for NJ Ex Order 26.4(b)(1).</p> <p>The deficient practice was evidenced by the following:</p> <p>On 02/10/2025 at 10:43 AM during the initial tour, Surveyor # 1 observed Resident # 100 in bed. At that time, Surveyor # 1 observed a NJ Ex Order 26.4(b)(1) in contact with the floor.</p> <p>A review of Resident # 100's Order Summary located in the Electronic Medical Record (EMR) revealed an order to, "Monitor and document [trade name] NJ Ex Order 26.4(b)(1) every shift. If no output in 8 hours notify MD every shift. The order revealed a start date of NJ Ex Order 26.4(b)(1).</p> <p>A review of the Treatment Administration Record located in the EMR revealed blanks in the documentation portion for the following dates:</p> <p>NJ Ex Order 26.4(b)(1) - Day - Blank NJ Ex Order 26.4(b)(1) - Evening - Blank NJ Ex Order 26.4(b)(1) - Evening - Blank NJ Ex Order 26.4(b)(1) - Day - Blank</p> <p>On 02/13/2025 at 12:36 PM during an interview</p>	F 690	<p>S690 D Bowel/Bladder Incontinence, Catheter, UTI</p> <p>1. The NJ Ex Order 26.4(b)(1) for Resident #100 was replaced and secured so that it was not touching the floor. A NJ Ex Order 26.4(b)(1) was also provided for this resident. A NJ Ex Order 26.4(b)(1) was provided to Resident #89 for their NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1). Staff who were responsible for the omissions documenting NJ Ex Order 26.4(b)(1) were provided with 1:1 education on the importance of documenting NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 were noted from these deficient practices for either resident.</p> <p>2. Residents who have catheter drainage bags had the potential to be affected by this deficient practice. An audit of all residents with catheter drainage bags was complete and found no other residents affected by this practice. Each resident had a privacy bag in place and no catheters or privacy bags were touching the floor.</p> <p>3. The Assistant Director of Nursing or designee provided re-education to the Unit Managers and licensed nursing staff on monitoring and documenting urinary output in the electronic health record per physician order. The Assistant Director of Nursing provided re-education to licensed and certified nursing staff on the importance of providing privacy bags to residents with catheter drainage bags to maintain dignity. Nursing staff were also</p>		

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F 690	<p>Continued From page 11</p> <p>with Surveyor # 1, the [U.S. FOIA (b) (6)] replied, "No" when asked if [NJ Ex Order 26.4(b)(1)] should be in contact with the floor. The [U.S. FOIA (b) (6)] further replied, "Infection" when the surveyor asked why not. Lastly, the [U.S. FOIA (b) (6)] replied, "If it's not documented it wasn't done." when the surveyor asked if urinary outputs are blank on the Treatment Administration Record, would you consider that administered.</p> <p>A review of the facility policy titled, "Urinary Catheters" with a review date of July 20, 2024 revealed under "Standards of Care for the Resident with an Indwelling Urinary Catheter" that, "The catheter collection tubing should be kept from kinking, and the collection bag should always be kept below the level of the bladder (and not touching the floor).</p> <p>N.J.A.C. § 8:39-27.1 (a) 2. Upon initial tour of the facility on 2/10/2025 at 10:20 AM, surveyor #2 observed from the hallway Resident #89's [NJ Ex Order 26.4(b)(1)] with no [NJ Ex Order 26.4(b)(1)].</p> <p>The surveyor reviewed the medical record for Resident #89.</p> <p>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: [NJ Ex Order 26.4(b)(1)]</p> <p>[NJ Ex Order 26.4(b)(1)]</p> <p>[NJ Ex Order 26.4(b)(1)]</p> <p>[NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)]</p>	F 690	<p>re-educated on the importance of ensuring catheter drainage bags are placed appropriately to maintain infection control practices.</p> <p>4. The Director of Nursing or designee will conduct weekly audits x 4 weeks, then monthly audits x 3 months to assure that residents who have catheter drainage bags have catheters positioned appropriately and in privacy bags to prevent any infection control issues and to maintain dignity. The Director of Nursing or designee will also audit for completion of urinary output in the electronic health record per physician order to assure compliance. Any untoward findings will be corrected immediately.</p> <p>The results of these audits and observations will be presented and reviewed at the Quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and to evaluate the need for further monitoring.</p>		

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F 690	<p>Continued From page 12</p> <p>A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [REDACTED] included the resident had a Brief Interview for Mental Status (BIMS) score of [REDACTED] out of 15, which indicated the resident's [REDACTED] as [REDACTED]. Review of Section [REDACTED] of the MDS identified Resident #89 with an [REDACTED].</p> <p>A review of the Medication Administration Treatment (MAR) included the following physician orders (PO):</p> <p>A PO, with a start date of [REDACTED], to Maintain [REDACTED] at all times check placement [every] shift. The date of [REDACTED] was checked with nurses' initials which indicated that the [REDACTED] was in place.</p> <p>A PO, with a start date of [REDACTED] to Monitor and document [REDACTED] output every shift. In no output in 8 hours notify [REDACTED]. Upon review of the [REDACTED] MAR the following date did not have an [REDACTED] entry: [REDACTED] Evening shift. Upon review of the [REDACTED] MAR the following date did not have an output entry: [REDACTED] Evening shift.</p> <p>A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated [REDACTED], that the resident was at risk for [REDACTED] [related to] [REDACTED]. Interventions included: [REDACTED] or [REDACTED] warranted to maintain dignity/privacy and provide [REDACTED] care every shift as ordered and (as needed) Monitor for decrease in [REDACTED].</p>	F 690			

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F 690	<p>Continued From page 13</p> <p>On 2/12/2025 at 12:13 PM, surveyor #2 interviewed Certified Nursing Assistant (CNA #1) who confirmed that [NJ Ex Order 26.4(b)(1)] were to be placed in [NJ Ex Order 26.4(b)(1)]. When asked how [NJ Ex Order 26.4(b)(1)] were monitored, CNA #1 responded that they will [NJ Ex Order 26.4(b)(1)], measure the amount, and report the [NJ Ex Order 26.4(b)(1)] to the nurse who was responsible for documenting the amount.</p> <p>On 2/12/2025 at 12:31 PM, surveyor #2 interviewed Unit Manager Licensed Nurse Practitioner (UMLPN #1) who confirmed that either the CNA or the nurse can empty the [NJ Ex Order 26.4(b)(1)] and measure the amount, but the nurse was responsible for documenting the amount in the chart. When asked how [NJ Ex Order 26.4(b)(1)] are to be maintained at bedside, UMLPN #1 reported that they were to be in a [NJ Ex Order 26.4(b)(1)]. When asked about blanks in the MAR, UMLPN#1 stated that there should never be blanks.</p> <p>On 2/12/2025 at 12:43 PM, surveyor #2 interviewed UMLPN #2 who confirmed that they were familiar with Resident #89. UMLPN #2 stated that [NJ Ex Order 26.4(b)(1)] were to be maintained in [NJ Ex Order 26.4(b)(1)] and that the nurses were responsible for documentation of the [NJ Ex Order 26.4(b)(1)]. Surveyor #2 provided pictures of the [NJ Ex Order 26.4(b)(1)] as observed on initial tour. UMLPN#2 confirmed the finding. When asked if there should be blanks on the MAR, UMLPN#2 denied.</p> <p>On 2/12/2025 at 1:47 PM, surveyor #2 interviewed the [U.S. FOIA (b) (6)], in the presence of the [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)] in</p>	F 690			

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F 690	Continued From page 14 Training, who viewed the surveyors pictures and acknowledged that the NJ Ex Order 26.4(b)(1) was not in NJ Ex Order 26.4(b)(1) and that NJ Ex Order 26.4(b)(1) were expected to be marked for every shift. A review of the facility's "Urinary Catheters" Policy, last reviewed 7/20/2024, included under the heading "Standards of Care for the Resident with an Indwelling Urinary Catheter": [...] Collection bags should be emptied from the spigot every shift using a separate collection container for each resident; a foley collection bag cover should be utilized to maintain resident dignity when in bed [...]. A review of the facility's "RN/LPN Job Description" document included under the heading "Documentation" included: A. All documentation is done in a timely manner, using appropriate formats; B. All documentation is properly identified, signed, and dated; C. Documentation [...] flow sheet information, and care plans are done legibly and filed appropriately [...].	F 690			
F 695 SS=E	N.J.A.C. 8:39-19.4 (a) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced	F 695			4/1/25

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F 695	<p>Continued From page 15</p> <p>by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide [redacted] care consistent with professional standards of practice by not storing [redacted] and [redacted] equipment in bags which resulted in [redacted] exposure for 3 of 5 residents reviewed for [redacted] use (Resident #22, 34, 89). The deficient practice was evidenced by the following:</p> <p>1. Upon initial tour of the facility on 2/10/2025 at 10:20 AM, surveyor #1 observed a [redacted] standing upright on a [redacted] located to the right of Resident #89 on the bedside table. The [redacted] was not bagged and exposed to the environment. Resident #89 was asleep and did not respond to surveyor #3's prompting.</p> <p>On 2/11/2025 at 9:16 AM, surveyor #3 observed a [redacted] standing upright on a [redacted] machine located to the right of Resident #89 on the bedside table. The [redacted] was not [redacted] and exposed to the environment.</p> <p>The surveyor reviewed the medical record for Resident #89.</p> <p>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: [redacted]</p>	F 695	<p>S695E Respiratory/Tracheostomy Care and Suctioning</p> <p>1. The [redacted] equipment found [redacted] for residents #22 and #89 were discarded and replaced with new equipment in proper storage bags. The [redacted] for Resident #34 was cleaned and [redacted] as appropriate. Resident #22 was assessed by the nurse and a [redacted] was obtained. Resident #22 had no [redacted] with a [redacted] reading. The [redacted] for Resident #22 was switched out immediately and a new one was put in place. The [redacted] for Resident #22 was assessed again after the [redacted] was switched and was found to have [redacted]. No [redacted] were noted from this deficient practice for any of the identified residents.</p> <p>2. Residents who have respiratory equipment had the potential to be affected by this deficient practice. An audit of all residents with respiratory equipment was conducted and found no other residents affected by this practice. Each resident had equipment bagged and stored appropriately to prevent exposure to the environment.</p> <p>3. The Respiratory Equipment Policy and Procedure was reviewed and determined no updates were required at this time.</p> <p>The Assistant Director of Nursing or designee provided re-education to the licensed and certified nursing staff on the importance of bagging respiratory equipment for proper storage to prevent</p>		

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F 695	<p>Continued From page 16</p> <p>NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1)</p> <p>A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4(b)(1) included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26.4(b)(1) out of 15, which indicated the resident's cognition as NJ Ex Order 26.4(b)(1).</p> <p>A review of the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) Medication Administration Treatment included the following physician orders (PO):</p> <p>A PO, with a start date NJ Ex Order 26.4(b)(1), for NJ Ex Order 26.4(b)(1)</p> <p>four times a day for NJ Ex Order 26.4(b)(1)</p> <p>On 2/12/2025 at 12:13 PM, surveyor #1 interviewed Certified Nursing Assistant (CNA #2) who confirmed that NJ Ex Order 26.4(b)(1) supplies were to be NJ Ex Order 26.4(b)(1) when not in use.</p> <p>On 2/12/2025 at 12:31 PM, surveyor #1 interviewed Unit Manager Licensed Nurse Practitioner (UMLPN #1) who stated that NJ Ex Order 26.4(b)(1) were to be stored NJ Ex Order 26.4(b)(1) to keep "clean" when not in use.</p> <p>On 2/12/2025 at 12:43 PM, surveyor #1 interviewed UMLPN #2 who confirmed that they were familiar with Resident #89. UMLPN #2 confirmed that NJ Ex Order 26.4(b)(1) were to be NJ Ex Order 26.4(b)(1)</p> <p>On 2/12/2025 at 1:47 PM, surveyor #1</p>	F 695	<p>exposure to the environment.</p> <p>4. The Director of Nursing or designee will conduct weekly audits x 4 weeks, then monthly audits x 3 months to assure that residents who have respiratory equipment have equipment bagged and stored appropriately to prevent exposure to the environment. Any untoward findings will be corrected immediately.</p> <p>The results of these audits and observations will be presented and reviewed at the Quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and to evaluate the need for further monitoring.</p>		

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F 695	<p>Continued From page 17</p> <p>interviewed the U.S. FOIA (b) (6), in the presence of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) in Training, who viewed the surveyors pictures and acknowledged that the NJ Ex Order 26.4(b)(1) were not NJ Ex Order 26.4(b)(1) are to be stored when not in use the U.S. FOIA (b) (6) replied, in a bag.</p> <p>A review of the facility's "Respiratory Equipment Policy and Procedure", last reviewed 8/5/2024, included: All nebulizer tubing and equipment shall be date and stored in an oxygen bag when not in use...</p> <p>N.J.A.C. 8:39-27(b)</p> <p>During the initial tour on 02/10/2025 at 09:56 AM, Resident #22 was observed lying in bed with NJ Ex Order 26.4(b)(1) in use. Surveyor #2 observed a NJ Ex Order 26.4(b)(1) laying NJ Ex Order 26.4(b)(1) on the resident's bedside table.</p> <p>On 02/11/2025 at 10:30 AM Surveyor #2 observed Resident # 22 in bed with NJ Ex Order 26.4(b)(1) on and the NJ Ex Order 26.4(b)(1) turned off. Surveyor #2 asked the Licensed Practical Nurse (LPN) # 2 if the resident should be on NJ Ex Order 26.4(b)(1). LPN # 2 stated yes and went in to check the resident. LPN #2 stated, "this should not be turned off". LPN # 2 NJ Ex Order 26.4(b)(1) back on and noticed the NJ Ex Order 26.4(b)(1) was not working properly. LPN #2 then replaced NJ Ex Order 26.4(b)(1) and checked resident's vitals.</p> <p>According to the Admission Record, Resident #22 was admitted to the facility with diagnoses including but not limited to; NJ Ex Order 26.4(b)(1),</p>	F 695			

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F 695	<p>Continued From page 18 and NJ Ex Order 26.4(b)(1) [REDACTED]</p> <p>A review of the most recent comprehensive Minimum Data Set (MDS) dated NJ Ex Order 26.4(b)(1), indicated Resident #22 was NJ Ex Order 26.4(b)(1) while a resident.</p> <p>A review of the Order Summary Report dated NJ Ex Order 26.4(b)(1), revealed a physician order for NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) every six hours. The order also revealed to NJ Ex Order 26.4(b)(1) after each use. The Order Summary Report also revealed and order to administer NJ Ex Order 26.4(b)(1) continuously.</p> <p>During an interview on 02/13/2025 at 11:16 AM with surveyor # 2 the U.S. FOIA (b) (6) NJ Ex Order 26.4(b)(1) said that all NJ Ex Order 26.4(b)(1) should be NJ Ex Order 26.4(b)(1) when not in use so that they don't pick up any bacteria.</p> <p>During an interview on 02/13/2025 at 12:36 PM with surveyor #2 the U.S. FOIA (b) (6) NJ Ex Order 26.4(b)(1) said that NJ Ex Order 26.4(b)(1) should be kept in plastic bags due to infection control. The U.S. FOIA (b) (6) also said that staff should be checking the NJ Ex Order 26.4(b)(1) to make sure they are on and properly functioning.</p> <p>A review of a facility provided policy titled "Respiratory Equipment Policy and Procedure" revealed, "all nebulizer equipment shall be dated and stored in an oxygen bag when not in use ..."</p>	F 695			

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F 695	<p>Continued From page 19 NJAC 8:39-27.1(a)</p> <p>Upon initial tour of the facility on 2/10/2025 at 10:27 AM, Surveyor #3 observed Resident # 34 [REDACTED] and [REDACTED] was on his/her dresser with the [REDACTED] to the environment.</p> <p>On 02/11/2025 at 10:35 AM, Surveyor #3 reviewed the electronic medical records (EMR) for Resident #34 as follows:</p> <p>According to the Admission Record Resident #34 was admitted to the facility with diagnoses including, but not limited to, [REDACTED] and [REDACTED].</p> <p>A review of Resident #34 most recent comprehensive Minimum Data Set (MDS) (an assessment tool used to facilitate the management of care) dated [REDACTED], revealed under section [REDACTED], that the resident had a Brief Interview for Mental Status (BIMS) (tool used to assess cognitive function in individuals) score of [REDACTED] out of 15, indicating the resident's cognition [REDACTED].</p> <p>A review of Resident #34 Physician Orders indicated the following: start date [REDACTED], the [REDACTED] is to be used every night at bedtime and removed in the morning, in addition to being used as needed for [REDACTED].</p> <p>During an interview with Surveyor #3 on 02/10/2025 at 10:35 AM during the initial tour,</p>	F 695			

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F 695	Continued From page 20 Resident #34 said that he/she NJ Ex Order 26.4(b)(1) when he/she sleeps. During an interview with Surveyor #3 on 02/12/2025 at 1:15 PM, the Licensed Practical Nurse Unit Manager #1 (LPNUM #1) said that NJ Ex Order 26.4(b)(1) equipment should be properly NJ Ex Order 26.4(b)(1) During an interview with Surveyor #3 on 02/13/2025 at 12:45 PM, the U.S. FOIA (b) (6) said that NJ Ex Order 26.4(b)(1) should be stored in a NJ Ex Order 26.4(b)(1) for infection control purposes. A review of the facility provided policy, with a review date of 08/05/2024, titled, "Respiratory Equipment Policy and Procedure" revealed under the section titled "Procedure" that, "All nebulizer tubing and equipment shall be date and stored in an oxygen bag when not in use and replaced every 7 days." N.J.A.C. 8:39-27(b)	F 695			
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755			4/1/25

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F 755	<p>Continued From page 21 biologicals) to meet the needs of each resident.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to establish a system of records for all controlled drugs in sufficient detail to enable an accurate reconciliation for the dispensing of controlled medications for 1 out of 3 medication carts inspected under the Medication Storage Task.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 02/12/2025 at 11:39AM in the presence of the Registered Nurse (RN)# 1, the surveyor inspected the medication cart on the subacute high side cart for storage and labeling of medications. During reconciliation of controlled medications, the surveyor observed 15 Oxycodone-Acetaminophen (a narcotic medication used to treat pain) in the blister pack</p>	F 755	<p>S755D Pharmacy Srvcs/Procedures/Pharmacist/Records</p> <p>1. No residents were affected by this deficient practice. RN #1 received re-education on maintaining narcotic administration records for all controlled drugs in sufficient detail to enable accurate reconciliation for the dispensing of controlled medications.</p> <p>2. Residents receiving narcotic medications had the potential to be affected. The Director of Nursing conducted an audit of residents with narcotic orders and determined no other residents were affected by this deficient practice. All narcotic medications were dispensed and accounted for in accurate detail.</p> <p>3. The policy on Medication Preparation</p>		

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F 755	Continued From page 22 in the narcotic box, but the Controlled Drug Sheet (CDS) documented 16 were left. At the same time on 02/12/2025 during the interview with the surveyor, RN #1 stated, "I just gave that sorry, I should have signed that out." When asked to see what time the medication was given, RN # 1 pulled up the medication on the medication administration record and stated, "10:27 AM". During an interview on 02/13/2025 at 12:36 PM with the surveyor, the U.S. FOIA (b) (6) said that narcotics should be signed out in the CDS when removed from the blister pack. Review of the facility's policy titled, "Medication Preparation for Administering" revised on 02/16/2022, revealed under "Medication Administration" that "4. As specified by federal and state regulations, controlled substances are documented as given at the time of administration."	F 755	for Administering was reviewed and determined no updates were required at this time. The Assistant Director of Nursing or designee provided re-education to the licensed nursing staff on signing out controlled medications in sufficient detail to enable an accurate reconciliation for the dispensing of controlled medications. The Director of Nursing or designee will conduct weekly audits x 4 weeks, then monthly audits x 3 months to assure that narcotic medications are signed out in detail to maintain accurate reconciliation for the dispensing of the narcotics. Any untoward findings will be corrected immediately. The results of these audits and observations will be presented and reviewed at the Quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and to evaluate the need for further monitoring.		
F 761 SS=D	NJAC 8:39-29.7(c) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		4/1/25	

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F 761	<p>Continued From page 23</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and facility provided documentation, it was determined that the facility failed to ensure all medical supplies were stored in accordance with professional standards by having expired supplies in 1 of 2 medication storage rooms inspected.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 02/12/2025 at 11:13 AM the surveyor in the presence of a Licensed Practical Nurse (LPN)# 1, observed the following in the subacute medication storage room:</p> <ol style="list-style-type: none"> 1. 6 unopened boxes of probe covers with an expiration date of 01/31/2025. 2. 2 opened boxes of colostomy bags with an expiration date of 01/2025. 3. 1 unopened box of paper medical tape with an expiration date of 12/2024. <p>During an interview on 02/12/2025 at 11:13 AM</p>	F 761	<p>761D Label/Store Drugs and Biologicals</p> <ol style="list-style-type: none"> 1. No residents were affected by this deficient practice. The expired probe covers, colostomy bags and paper tape were removed and discarded from the medication storage rooms. 2. Residents receiving treatment items from the medication storage room identified had the potential to be affected. Medication storage rooms were audited for expired items, both drugs and biologicals. No other items were found expired. No residents were affected by this deficient practice. 3. The Assistant Director of Nursing or designee provided re-education to the licensed nursing staff on ensuring all medical supplies are stored in accordance with professional standards and to remove and discard any expired items when identified. 4. The Director of Nursing or designee 		

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F 761	Continued From page 24 with the surveyor LPN #1 said there should not be any expired medical supplies in the storage room and she removed the items. During an interview on 02/14/2025 at 12:36 PM with the surveyor the U.S. FOIA (b) (6) said he was unaware of expiration dates on supplies, and he would be checking them from now on. The U.S. FOIA (b) also said that there should not be expired items in the storage room. Facility unable to provide a policy on expired supplies. N.J.A.C 8:39-29.4 (g) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 761	will conduct weekly audits x 4 weeks, then monthly audits x 3 months to assure that the storage of drugs and biologicals are in accordance with professional standards to assure no items are expired. Any untoward findings will be corrected immediately. The results of these audits and observations will be presented and reviewed at the Quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and to evaluate the need for further monitoring.		
F 812 SS=E		F 812			4/1/25

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F 812	<p>Continued From page 25</p> <p>by:</p> <p>Based on observation, interview, and pertinent facility documents, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following:</p> <p>On 02/10/2025 from 09:17 AM until 10:15 AM, the surveyor observed the following in the kitchen in the presence of the U.S. FOIA (b) (6) then the U.S. FOIA (b) (6):</p> <ol style="list-style-type: none"> 1. In refrigerator #1 on the bottom right shelf there were shelled eggs in a carton that were out of the cardboard box. The PC stated the eggs should be stored in the original container. 2. On a storage shelf, souffle cups were opened and exposed to air. The U.S. FOIA (b) (6) stated the cups should be covered. 3. In refrigerator #2 there were 20 small cups of mixed fruit that were labeled prepared 2/6/25 discard by 2/8/25 on a metal tray. The U.S. FOIA (b) (6) stated he is going to discard them as they are not labeled properly. 4. In freezer #4 there were hash brown patties that were opened and covered with plastic wrap. The hash brown patties were not labeled or dated. The U.S. FOIA (b) (6) stated he will discard the hash brown patties. 5. In refrigerator # 3 there were florets of broccoli stored in a blue crate in a black bag that was opened to air. There was no label and no date. The U.S. FOIA (b) (6) stated that the broccoli should be labeled and dated. 	F 812	<p>F812 – Scope and Severity - E</p> <p>Labeling and Dating</p> <ul style="list-style-type: none"> • In refrigerator #1 on the bottom right shelf there were shelled eggs in a carton that were out of the cardboard box. The PC stated the eggs should be stored in the original container. • In refrigerator #2 there were 20 small cups of mixed fruit that were labeled prepared 2/6/25 discard by 2/8/25 on a metal tray. • In freezer #4 there were hash brown patties that were opened and covered with plastic wrap. The hash brown patties were not labeled or dated. The RFSD stated he will discard the hash brown patties. • In refrigerator # 3 there were florets of broccoli stored in a blue crate in a black bag that was opened to air. There was no label and no date. • In refrigerator #4 an opened case of cranberry juice was not labeled or dated. The RFSD stated the cranberry juice should be labeled and dated. He stated the case was labeled, however when staff opened the case, the label was ripped off. <p>1.WHAT CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE Step 1-</p>		

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F 812	<p>Continued From page 26</p> <p>6. In refrigerator #4 an opened case of cranberry juice was not labeled or dated. The U.S. FOIA (b) (6) stated the cranberry juice should be labeled and dated. He stated the case was labeled, however when staff opened the case, the label was ripped off.</p> <p>During an interview on 02/14/25 at 10:29 AM, the U.S. FOIA (b) (6) stated the broccoli should have been labeled and dated. The eggs should have been in a cardboard box. The cranberry juice was labeled and dated however once box was opened the label ripped off.</p> <p>The surveyor reviewed the facility provided policy titled, "Sun Cups (juices)" with a revision date of 11/3/17 which reflected: all sun cups upon delivery are to be dated.</p> <p>The surveyor reviewed the facility provided policy titled, "Labeling and Dating" with no date which reflected all leftover perishable and non-perishable food products should be labeled and dated to assure all food is being served in a safe and sanitary manor.</p> <p>The surveyor reviewed the facility provided policy titled, "Food Storage", with no date which reflected: 14. Frozen Foods c. All foods should be covered, labeled, and dated.</p> <p>The surveyor reviewed the facility provided policy titled, "Storage Areas", with no date which reflected that all paper products should be wrapped in original container or tightly wrapped when not in use.</p> <p>NJAC 8:39-17.2(g)</p>	F 812	<ul style="list-style-type: none"> No residents were identified as having negative impact from this deficient practice. <p>Step 2 HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN</p> <ul style="list-style-type: none"> Residents residing in the facility have the potential to be affected. <p>Step 3 WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR</p> <ul style="list-style-type: none"> A new Audit tool was developed to assure compliance in deficient practice. The management closing check list was updated to reflect identified areas to ensure compliance. (See attached closing check list) An in-service was given to all staff on labeling and dating and proper food storage assuring all items are covered. An in-service was given to all supervisors on the updated closing check list. <p>Step 4 HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND</p>		

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F 812	Continued From page 27	F 812	<p>WILL NOT REOCCUR. I.E. WHAT PROGRAM WILL BE PUT INTO PLACE TO MONITOR THE CONTINUED EFFECTIVENESS OF THE SYSTEMIC CHANGE</p> <ul style="list-style-type: none"> FSD/Designee will conduct daily checks on a newly developed audit tool to ensure compliance for a period of 1 month. After 1 month, FSD/designee will conduct weekly checks on a newly developed audit tool weekly for a period of 2 months. After 2 months, FSD/designee will conduct quarterly checks using the audit tool for a period of 9 months. FSD/designee will conduct audits on newly developed closing checklist daily. FSD/designee will report trends to quality assurance the next four quarters to assure compliance. 		
F 814 SS=D	<p>Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4)</p> <p>§483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide a sanitary environment by failing to a.) keep the garbage container area free of debris and b.) have a closed cover over the opening the garbage container.</p> <p>This deficient practice was evidenced by the following:</p>	F 814	<p>F814D Dispose of Garbage and Refuse Properly 1. No residents were affected by this deficient practice. An extra dumpster was obtained by the Administrator and all items identified on the ground were removed and discarded. The cardboard boxes observed on the ground were picked up and discarded and the</p>		4/1/25

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F 814	Continued From page 28 On 02/11/25 at 01:09 PM, the surveyor observed the outside garbage area. There were wooden pallets, broken orange plastic pieces, a recliner chair with a rolled-up carpet on top of it, a geriatric chair, a medical glove, a gray container labeled trash, and a commode. These items were not in a container and were in proximity of vehicles. The surveyor observed a green garbage container filled with cardboard boxes. The garbage container was opened on one side exposing the cardboard boxes inside. On 02/12/25 at 11:27 AM, the surveyor observed the garbage area again. There were cardboard boxes spilling out of the garbage container, on the ground, and on top of the half-closed lid. On 02/12/25 at 11:53 AM, the U.S. FOIA (b) (6) stated that the trash is picked up twice per week and if there is overflow then the facility calls the company to pick up. On 02/13/25 at 09:29 AM, the U.S. FOIA (b) (6) stated that the garbage and refuse was cleaned up properly. He acknowledged that the cardboard should not have been on the ground and should have been covered. The U.S. FOIA (b) (6) stated that the facility did not have a policy that addressed the outside garbage containers. NJAC 8:39-19.7 Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5)	F 814	dumpster was covered by the lid. 2. No residents had the potential to be directly affected by this outside dumpster. 3. The Administrator educated the housekeeping and maintenance staff on the importance of maintaining a clean garbage area to maintain a sanitary environment. 4. The Administrator or designee will conduct weekly audits x 4 weeks, then monthly audits x 3 months to ensure that the outside garbage area is clean and maintains a sanitary environment. Any untoward findings will be corrected immediately. The results of these audits and observations will be presented and reviewed at the Quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and to evaluate the need for further monitoring.		
F 842 SS=D		F 842		4/1/25	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/14/2025
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F 842	Continued From page 29 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842			

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F 842	<p>Continued From page 30 by and in compliance with 45 CFR 164.512.</p> <p>§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(h)(4) Medical records must be retained for-</p> <ul style="list-style-type: none"> (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. <p>§483.70(h)(5) The medical record must contain-</p> <ul style="list-style-type: none"> (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, it was determined that the facility failed to maintain a complete and readily accessible medical records. This deficient practice was identified for 1 of 29 residents reviewed, Resident #70 and was evidenced by the following:</p> <p>On 02/10/2025 at 11:20 AM, the surveyor observed Resident #70 in bed. Resident #70 states he/she feels great.</p>	F 842	<p>F842D Resident Records-Identifiable Information</p> <p>1. Resident #70 was NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) once the resident's responsible party consented to services. Resident #70 remains as NJ Ex Order 26.4(b)(1) in the facility with NJ Ex Order 26.4(b)(1) from this deficient practice. The electronic health record for Resident #70 was updated to include information on the hospice services provided.</p>		

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F 842	<p>Continued From page 31</p> <p>The surveyor reviewed Resident #70's electronic health record and observed a Physician Order dated [REDACTED] [REDACTED] evaluation and treat. There was no other documentation in the electronic health record including the care plans and progress notes regarding [REDACTED].</p> <p>Further review of the medical record revealed the resident was admitted to the facility with diagnoses which included [REDACTED] and [REDACTED]. The [REDACTED] minimum data set, an assessment tool, reflected that this resident was [REDACTED] and was [REDACTED].</p> <p>On 02/11/25 at 09:13 AM, the surveyor reviewed the [REDACTED] binder and the consultation binder at the nurse station no paperwork for Resident # 70 observed.</p> <p>On 02/12/25 at 01:51 PM, during an interview with the [REDACTED] she stated that her and the [REDACTED] met with Resident #70's family and the family wanted to pursue [REDACTED]. The [REDACTED] stated that there definitely should have been documentation in the electronic health record. She acknowledged that there was no documentation regarding [REDACTED] for this resident.</p> <p>On 02/13/25 at 09:47 AM, during an interview with the [REDACTED], he stated there should have been documentation in the electronic health record regarding the [REDACTED] consult.</p> <p>On 02/13/2025 at 11:59 AM, the surveyor reviewed the electronic medical record and observed nurse's notes dated 02/12/2025 (after surveyor inquiry) regarding a conversation with Resident #70's family regarding [REDACTED].</p>	F 842	<p>2. Residents with physician orders for consultations had the potential to be affected by this deficient practice. An audit of resident orders for consultations was conducted by the Director of Nursing. No other residents were found to be affected by this practice. All physician orders for consults had corresponding documentation following orders.</p> <p>3. The Medical Records Policy and Procedures was reviewed by administration and determined there were no updates required at this time to the policy.</p> <p>The Assistant Director of Nursing or designee provided re-education to the licensed nursing staff and Social Services on ensuring follow-up is documented in the electronic health record for physician orders and when meetings are held with residents and/or family members related to the resident's plan of care.</p> <p>4. The Director of Nursing or designee will conduct weekly audits x 4 weeks, then monthly audits x 3 months to ensure that follow up documentation is noted in the electronic health record for consultation orders to ensure compliance. Any untoward findings will be corrected immediately.</p> <p>The results of these audits and observations will be presented and reviewed at the Quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and to evaluate the need for further monitoring.</p>		

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F 842	Continued From page 32	F 842			
F 880 SS=D	<p>A review of the facility provided policy titled, "Medical Records Policy and Procedure", with no date reflected that the medical record shall be available and include at least the following information: consultation reports, if a part of a care plan is not implemented, the record shall explain why.</p> <p>NJAC 8:39-35.2 (d)(5) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and</p>	F 880			4/1/25

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F 880	<p>Continued From page 33</p> <p>procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its</p>	F 880			

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F 880	<p>Continued From page 34</p> <p>IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of pertinent facility documents it was determined that the facility staff failed to use appropriate infection control practices specifically by not following proper technique with personal protective equipment (PPE) on 1 of 3 units observed. The deficient practice was evidenced by the following:</p> <p>On 02/10/2025 at 9:53 AM during initial tour of the facility the surveyor observed a certified nursing assistant (CNA) walk out of resident # 58's room, down the hall to the soiled utility room and back wearing a gown and gloves. The resident's room had an NJ Ex Order 26.4(b)(1) [REDACTED] sign on the door.</p> <p>A review of Resident #58's electronic medical record revealed a physician's order to maintain NJ Ex Order 26.4(b)(1) [REDACTED] related to [REDACTED].</p> <p>During an interview on 02/13/2025 at 11:02 AM with the surveyor, the Licensed Practical Nurse (LPN)#1 said that gowns should be removed before leaving the resident's room.</p> <p>During an interview on 02/13/2025 at 11:10 AM with the surveyor, the CNA # 1 said you should not leave the room with a gown on, and that it should be removed before leaving the room.</p>	F 880	<p>F880D Infection Prevention & Control</p> <p>1. Resident #58 remains on NJ Ex Order 26.4(b)(1) [REDACTED] and had NJ Ex Order 26.4(b)(1) [REDACTED] from this deficient practice. The CNA who was observed walking in the hallway wearing personal protective equipment (PPE) received 1:1 re-education on proper donning and doffing of PPE for enhanced barrier precautions.</p> <p>2. Residents on the unit had the potential to be affected by this deficient practice. An audit was conducted upon notification of this instance by the Infection Prevention Nurse. No other staff were observed with PPE in the hallways. No other residents were affected by this practice.</p> <p>3. The Enhanced Barrier Precautions Policy and Procedure was reviewed, and it was determined that no updates to the policy were required at this time. The Infection Prevention Nurse or designee provided re-education to the nursing staff on proper donning and doffing of PPE to ensure compliance with enhanced barrier precautions.</p> <p>4. The Infection Prevention Nurse or designee will conduct weekly audits x 4 weeks, then monthly audits x 3 months to ensure that staff don and doff personal protective equipment as required for residents with enhanced barrier precautions to maintain compliance. The results of these audits and observations will be presented and</p>		

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F 880	<p>Continued From page 35</p> <p>During an interview on 02/13/2025 at 11:16 AM with the surveyor, the U.S. FOIA (b) (6) said, they had just had an in-service on wearing gowns in the hallway and that they should be removed before leaving the residents room and placed in the covered trash cans due to infection control.</p> <p>A review of a facility provided policy titled "Enhanced Barrier Precautions" revised on 02/04/2025, revealed under "Procedure" that, "Solid linen and trash bins will be placed inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room ..."</p> <p>N.J.A.C. 8:39-19.4(c)</p>	F 880	<p>reviewed at the Quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and to evaluate the need for further monitoring.</p>		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061504	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/14/2025
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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 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: Based on interview, and review of pertinent facility documentation, 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. This deficient practice was evidenced by the following: Findings include: A.) Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey	S 560	S560 Mandatory Access to Care 1. The facility had 17 certified nurse aides instead of 18 certified nurse aides as required on 1/26/2025 for the day shift out of the two weeks observed. No residents were identified as being affected by this practice. 2. Residents in the facility had the potential to be affected. No grievance reports or verbalizations were received from residents, staff or family members regarding the day shift staff on 1/26/2025 where the facility fell short by one certified nurse aide. All other shifts during the two-week observation period for staffing	4/1/25

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

TITLE

(X6) DATE

Electronically Signed

03/10/25

New Jersey Department of Health

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S 560	<p>Continued From page 1</p> <p>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:</p> <p>One Certified Nurse Aide (CNA) to every eight residents for the day shift.</p> <p>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</p> <p>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.</p> <p>For the 2 weeks of staffing prior to survey from 01/26/2025 to 02/08/2025, the facility was deficient in CNA staffing for residents on 1 of 14 evening shifts as follows:</p> <p>-01/26/2025 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs.</p> <p>During an interview on 02/13/2025 at 11:24 AM with the surveyor, the Staffing Coordinator (SC) was asked about the facility's ability to meet staff requirements. The SC responded, "The facility meets its staffing needs. We evaluate staffing levels daily according to the residents' needs, taking into account both the facility's census and the required level of care, along with daily reassessments."</p> <p>A review of a facility provided policy, with a review</p>	S 560	<p>met all staffing requirements. No residents were affected by this practice.</p> <p>3. The facility Call out Policy and Staffing Policy have been reviewed by Administration. It was determined that no updates are required at this time to either policy.</p> <p>The Assistant Director of Nursing or designee re-educated staff on the facility call out policy.</p> <p>The facility currently has contracts with agencies, offers bonuses and has referral and sign-on bonuses for staffing.</p> <p>Depending on the needs of the day, nursing management to include Unit Managers, Supervisors and the Assistant Director of Nursing are evaluated to provide assistance with resident care as needed.</p> <p>4. The Administrator or designee will conduct weekly audits x 4 weeks, then monthly audits x 3 months to ensure that the facility maintains the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey.</p> <p>The results of these audits and observations will be presented and reviewed at the Quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and to evaluate the need for further monitoring.</p>	

New Jersey Department of Health

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S 560	Continued From page 2 date of 10/2024, titled "Staffing Policy " revealed under the section titled " Procedure" that, " Certified nursing assistants will be available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan and with the following ratios: One certified nurse aide to every eight residents for the day shift. One direct care staff member to every ten residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each direct care staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties. One direct care staff member to every fourteen residents for the night shift, provided that each direct care staff member shall be signed in to work as a certified nurse aide and perform certified nurse aide duties."	S 560			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315115	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 4/8/2025	Y3
NAME OF FACILITY ATLANTIC COAST REHAB & HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 485 RIVER AVE LAKEWOOD, NJ 08701		

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0656	Correction	ID Prefix F0690	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.25(e)(1)-(3)	Completed
LSC	04/01/2025	LSC	04/01/2025	LSC	04/01/2025
ID Prefix F0695	Correction	ID Prefix F0755	Correction	ID Prefix F0761	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	04/01/2025	LSC	04/01/2025	LSC	04/01/2025
ID Prefix F0812	Correction	ID Prefix F0814	Correction	ID Prefix F0842	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.60(i)(4)	Completed	Reg. # 483.20(f)(5), 483.70(h)(1)-(5)	Completed
LSC	04/01/2025	LSC	04/01/2025	LSC	04/01/2025
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/01/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
2/14/2025

☐ 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 061504	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 4/8/2025
NAME OF FACILITY ATLANTIC COAST REHAB & HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 485 RIVER AVE LAKEWOOD, NJ 08701	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/01/2025	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 <input type="checkbox"/>		REVIEWED BY (INITIALS)		DATE	
REVIEWED BY CMS RO <input type="checkbox"/>		REVIEWED BY (INITIALS)		DATE	
FOLLOWUP TO SURVEY COMPLETED ON 2/14/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			

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

PRINTED: 07/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/18/2025
NAME OF PROVIDER OR SUPPLIER ATLANTIC COAST REHAB & HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 485 RIVER AVE LAKEWOOD, NJ 08701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments	E 000			
K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 2/14/25 and 2/18/25. The facility was found not to be in compliance with 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.</p> <p>The facility is one story building with 3-partial lower levels:</p> <ol style="list-style-type: none"> 1). therapy gym 2). sleep health tenant 3). lower level occupied with tenants and back of building with utilities <p>The facility was opened in the 70's and is Type II (222) construction with complete sprinkler system and complete fire alarm system with smoke detection in all corridors and bedrooms. The facility has a 300 KW (kilowatt) exterior diesel generator that powers 100% of the building. The facility has eight smoke compartments. It has 140 occupied beds and is licensed for 160.</p>	K 000			
K 293 SS=E	Exit Signage CFR(s): NFPA 101	K 293			4/1/25

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

TITLE

(X6) DATE

Electronically Signed

03/10/2025

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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NAME OF PROVIDER OR SUPPLIER ATLANTIC COAST REHAB & HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 485 RIVER AVE LAKEWOOD, NJ 08701		
(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 293	<p>Continued From page 1</p> <p>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 2/18/25 in the presence of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6), it was determined that the facility failed to ensure that exits were marked by an approved sign that was 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 potential to affect 60 of 140 residents and was evidenced by the following:</p> <p>1). An observation at 11:31 AM revealed that the lower level therapy gym was provided with only 1-illuminated exit sign by the elevator exit/egress doors. The opposite line of exit travel was by the 2nd set of exit/egress doors. It was observed that there was no exit sign showing the direction of travel at that set of doors.</p> <p>2). Observations from 09:30 AM to approximately 1:05 PM with the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) revealed in the exit/egress corridors of the facility, that when the set of smoke doors were closed</p>	K 293	<p>POC K293 E Column 1 No residents were identified as having negative impact from this deficient practice. Column 2 The deficient practice had the potential to affect 60-140 residents residing at this facility according to the 2567. Column 3 The facility will ensure that illuminated exit signs are installed in the therapy gym and by resident rooms 37&38 and resident rooms 74&74 see attached pictures Column 4 The Director of Maintenance or designee will conduct weekly audits to observe that all exit signs are in place and working. Any untoward findings will be corrected immediately. The results of these audits and observations will be presented and reviewed at the Quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and to evaluate the need for further monitoring.</p>		

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NAME OF PROVIDER OR SUPPLIER ATLANTIC COAST REHAB & HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 485 RIVER AVE LAKEWOOD, NJ 08701		
(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 293	Continued From page 2 from the electro-magnetic door open device, there was no illuminated exit sign on one side of the smoke doors. The nearest exit was not apparent for 1 of 2 sides of the smoke doors in the following areas: Floor #1 by resident rooms 37 and 38. Floor #1 by resident rooms 73 and 74. In interviews at the time, the [U.S. FOIA (b)(6)] and [U.S. FOIA (b)(6)] confirmed the observations. The [U.S. FOIA (b)(6)] was informed of the deficient practices at the Life Safety Code exit conference on 2/18/25 at 12:45 PM.	K 293	Column 5 Date of compliance: April 1, 2025		
K 363 SS=F	N.J.A.C 8:39-31.2 (e) 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	K 363		4/1/25	

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NAME OF PROVIDER OR SUPPLIER ATLANTIC COAST REHAB & HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 485 RIVER AVE LAKEWOOD, NJ 08701		
(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 363	<p>Continued From page 3</p> <p>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 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.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and interview on 2/14/25 in the presence of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6), it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101: 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice was identified for 7 of 37 resident rooms observed, had the potential to affect 50 of 140 residents and was evidenced by the following:</p> <p>Observations from 9:15 AM to 12:45 PM in the presence of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) revealed resident room doors did not operate properly as follows:</p> <p>- Room #53 - The door-side resident privacy</p>	K 363	<p>POC K363 E Column 1 No residents were identified as having negative impact from this deficient practice. Column 2 The deficient practice had the potential to affect 50-140 residents residing at this facility according to the 2567. Column 3 The facility will reinstall the track that holds the curtain a few inches away from door so it will close properly. This will be done for every room on the unit that was identified as having the issues of doors not closing all the way. Column 4</p>		

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NAME OF PROVIDER OR SUPPLIER ATLANTIC COAST REHAB & HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 485 RIVER AVE LAKEWOOD, NJ 08701		
(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 363	<p>Continued From page 4</p> <p>curtain obstructed the door from fully closing into its frame.</p> <ul style="list-style-type: none"> - Room #58 - The door-side resident privacy curtain obstructed the door from fully closing into its frame. - Room #65 - The door-side resident privacy curtain obstructed the door from fully closing into its frame. - Room #66 - The door-side resident privacy curtain obstructed the door from fully closing into its frame. - Room #67 - The door-side resident privacy curtain obstructed the door from fully closing into its frame. - Room #80 - The door-side resident privacy curtain obstructed the door from fully closing into its frame. - Room #85 - The door-side resident privacy curtain obstructed the door from fully closing into its frame. <p>In an interview at 12:00 PM, the [U.S. FOI] and [U.S. FOIA (b)(6)] confirmed the findings.</p> <p>The [U.S. FOIA (b)(6)] was informed of the deficient practice at the Life Safety Code exit conference on 2/18/25 at 12:45 PM.</p> <p>NJAC 8:39-31.1(c), 31.2(e)</p>	K 363	<p>The Director of Maintenance or designee will conduct weekly audits x 4 weeks, then monthly audits x 3 months to ensure that the doors close completely. The results of these audits and observations will be presented and reviewed at the Quarterly Quality Assurance Meeting x 2 quarters for necessary suggestions or improvements and to evaluate the need for further monitoring.</p> <p>Column 5 Date of compliance: April 1, 2025</p>		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315115	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	DATE OF REVISIT 4/8/2025
NAME OF FACILITY ATLANTIC COAST REHAB & HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 485 RIVER AVE LAKEWOOD, NJ 08701	

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. #	Completed
LSC K0293	04/01/2025	LSC K0363	04/01/2025	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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 2/18/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			