STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315340	A. BUILDING _____ B. WING _____	C 02/08/2024

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SEASHORE GARDENS LIVING CENTER	22 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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F 000	INITIAL COMMENTS Complaint NJ #: 163257; 165358; 166548; 168222; 168566; 169298; 170029; 170523 STANDARD SURVEY: 02/08/2024 CENSUS: 144 SAMPLE SIZE: 33 + 8 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Complaint NJ #: 168222 and 168566 Based on interview, record review, and review of facility documents, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for 2 of 7 residents (Resident #104 and 251) reviewed for accidents. This deficient practice was evidenced by the following: 1. On 1/30/24 at 11:57 AM, during the initial tour, Resident #104 was not in his/her room. A staff member identified Resident #104 in the dayroom	F 641	1.The quarterly MDS assessment for Resident #104 modified and updated to capture the [redacted] and was submitted and accepted on 2/6/24. Resident # 251 was no longer at our facility. The MDS coordinator modified the quarterly MDS assessment and assessment transmitted and accepted on 2/6/24. MDS assessments submissions for past 30 days reviewed for accuracy. MDS Coordinator was re-educated on accuracy of assessments. 2.All residents with falls may be affected by MDS Coordinator not reviewing all available sources for any fall since the last	3/15/24

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

Electronically Signed | 03/01/2024

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F 641	Continued From page 1 sitting in a NJ Exec. Order 26:4.b.1 [redacted] The surveyor reviewed the medical record for Resident #104. According to the Admission Record (AR), Resident #104 had diagnoses which included, but were not limited to, NJ Exec. Order 26:4.b.1 [redacted] A review of the quarterly MDS, dated NJ Exec. Order 26:4 [redacted] reflected the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec. Order [redacted] which indicated a NJ Exec. Order 26:4.b.1 [redacted] and the resident NJ Exec. Order 26:4.b.1 [redacted]. Further review of the MDS reflected the resident had a history NJ Exec. Order 26 [redacted] A review of the Incident Case Report that was provided by the facility revealed the following: On NJ Exec. Order 26:4 [redacted] the resident had NJ Exec. Order 26:4.b.1 [redacted] and had NJ Exec. Order 26:4.b.1 [redacted] noted to the NJ Exec. Order 26:4.b [redacted]. On NJ Exec. Order 26:4 [redacted] the resident had NJ Exec. Order 26:4.b.1 [redacted] with NJ Exec. Order 26:4.b.1 [redacted] of NJ Exec. Order 26:4.b.1 [redacted] noted. On NJ Exec. Order [redacted] the resident had NJ Exec. Order 26:4.b.1 [redacted] with NJ Exec. Order 26:4.b.1 [redacted] or NJ Exec. Order [redacted] noted. Further review of the quarterly MDS in Section J: Health Conditions under J1900, indicated the resident only had NJ Exec. Order 26:4.b.1 [redacted] with NJ Exec. Order 26:4.b [redacted], and NJ Exec. Order 26:4 [redacted] with NJ Exec. Order 26:4.b.1 [redacted], NJ Exec. Order 26:4.b.1 [redacted].	F 641	assessment and/or review nursing home incident reports and medical record (physician, nursing, therapy, and nursing assistant notes) for falls and level of injury and/ or Determine the number of falls that occurred since admission/entry or reentry and/or prior assessment and code the level of fall-related injury for each. MDS Coordinator will review past 4 weeks of quarterly assessments for falls and will do modification if a fall incidence not captured. 3.In-service completed with all MDS Coordinators regarding documented falls and accuracy of assessments. MDS Coordinators will review falls weekly will audit weekly with unit managers to ensure all falls documented are included in the MDS submissions. 4.DON or designee will audit 5 MDS assessments per month for 3 months prior to submission and will report findings quarterly to Quality Assurance Performance Improvement Committee.	

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Continued From page 2

Further review of the MDS did not reflect the [redacted].

A review of the of Progress Note (PN) from [redacted], reflected the resident had an [redacted] and upon assessment the nurse found a [redacted] on the resident [redacted].

On 2/6/24 at 11:19 AM, Regional Nurse #1 stated in the presence of the Licensed Nurse Home Administrator (LNHA), the Director of Nursing (DON), Regional Nurse #2, the Regional LNHA and the survey team that the [redacted] MDS for Resident #104 was coded inaccurately and acknowledged that [redacted] was missed and should have been documented.

2. According to the AR, Resident #251 had diagnoses which included, but were not limited to, [redacted].

Review of the significant change in status MDS, dated [redacted], included in Section J: Health Conditions that the resident did not have [redacted] since the prior assessment.

Review of the MDS list in the resident's Electronic Medical Record (EMR) included that the last MDS assessment prior to [redacted] was dated [redacted].

Review of the care plan, revised [redacted], included, "[redacted] due to [redacted] and [redacted]

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F 641	Continued From page 3	F 641		

Review of a PN, dated [redacted] at 3:30 AM, revealed that the Certified Nursing Assistant (CNA) observed Resident #251 slide out of bed, and due to the resident requiring a maximum assistance of [redacted], was unable to prevent the incident. Further review of the progress note included that the resident [redacted].

Review of a PN, dated [redacted] at 1:02 PM, revealed that Resident #251's family member observed the resident [redacted] his/her room. Further review of the PN included that the resident did not have [redacted]

During an interview with the surveyor on 02/05/24 at 12:46 PM, the MDS Coordinator (MDSC) stated she reviews nursing documentation from the EMR to complete the MDS assessments. The MDSC further stated that she reviews the Risk Management section in the EMR which lists all the falls in the previous three months in order to determine if the resident has had any falls since the prior MDS assessment. When asked how falls are captured on the MDS assessment, the MDSC stated that falls are coded three ways - if the resident had no injury, if the resident had a minor injury, and if the resident had a major injury. The MDSC and the surveyor then reviewed Resident #251's MDS assessments. The MDSC then verified that [redacted] and [redacted] should have been captured on the resident's [redacted] MDS assessment.

During an interview with the surveyor on 02/06/24 at 11:30 AM, the Director of Nursing (DON) stated that the MDSC was responsible for completing

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F 641	Continued From page 4 the MDS assessments. The DON further stated that she would expect the MDSC to complete the MDS assessments accurately. When informed of Resident #251's NJ Exec. Order 26:4.b.1 MDS assessment, the DON stated that NJ Exec. Order 26:4.b.1 should have been captured. Review of the Review of the Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2023s, included instructions for Section J: Health Conditions. According to the manual, staff are to, "Review all available sources for any fall since the last assessment," and, "review nursing home incident reports and medical record (physician, nursing, therapy, and nursing assistant notes) for falls and level of injury." The manual further includes to "Determine the number of falls that occurred since admission/entry or reentry or prior assessment and code the level of fall-related injury for each." NJAC 8:39-11.1	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		3/15/24

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F 656	Continued From page 5 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 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility documents, it was determined that the facility failed to develop a person-centered	F 656	1.Immediate Corrective Action Residents identified as: #145 #301 #253. Resident #253 no longer at the facility. An	

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F 656	Continued From page 6 comprehensive care plan to include residents' a.) preference for activities and b.) risk for pain. This deficient practice was identified for 1 of 1 resident (Resident #253) reviewed for activities and for 2 of 2 residents (Resident #145 and #301) reviewed for NJ Exec. Order 26:4.b.1 and was evidenced by the following: 1. On 01/30/24 at 10:39 AM, the surveyor observed Resident #253 sitting in a wheelchair in his/her room. The resident stated that he/she would like to go to activities, but that there is no one to take him/her. According to the Admission Record, Resident #253 had diagnoses which included, but were not limited to, NJ Exec. Order 26:4.b.1 Review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated, NJ Exec. Order 26:4.b, included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec. Orde which indicated the resident's cognition was NJ Exec. Order 26:4.b.1. Further review of the MDS included it was very important to the resident to NJ Exec. Order 26:4.b.1 and, NJ Exec. Order 26:4.b.1 Review of the Recreation Assessment, dated NJ Exec. Order 26:4.b, included, NJ Exec. Order 26:4.b.1 ." Review of the care plan, initiated NJ Exec. Order 26:4.b, did not include the resident's preferences for activities or interventions to ensure the resident's	F 656	immediate review was completed on resident care plans and updated appropriately. Appropriate staff were immediately educated on the importance of completing comprehensive care plans per policy. Full house care plan audit was conducted to ensure residents needed were care planned appropriately. 2.All residents have the potential to be affected by this alleged deficient practice; no other residents were identified as being negatively impacted. 3.DON/Designee will ensure that the baseline care plan is completed timely after admission by reviewing the resident in morning clinical meeting. At this time the care plan in its entirety will be reviewed and updated as necessary. An audit tool was implemented, it includes checking the resident□s care plan to ensure residents comprehensive needs. The Unit Manager will conduct this audit weekly and check that all appropriate care plans are in place. 4.The DON/Designee will review audits monthly for 6 months and will submit findings quarterly to Quality Assurance Performance Improvement.	

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activity preferences were met.

During an interview with the surveyor on 02/01/24 at 11:52 AM, the Activities Director (AD) stated that the activities staff complete an initial assessment when residents are admitted to determine their activity preferences.

During an interview with the surveyor on 02/01/24 at 12:10 PM, the Assistant Activities Director (AAD) stated that every resident was assessed for activity preferences upon admission to the facility. The AAD further stated she completed the Resident #253's Recreation Assessment, and that the resident was NJ Exec. Order 26:4.b.1 was available for the resident to attend.

During a follow-up interview with the surveyor on 02/06/24 at 9:32 AM, the AD stated that the assigned activities staff member will document a resident's Recreation Assessment in the Electronic Medical Record (EMR) and then initiate a care plan related to the resident's preferences. The AD further stated that the activities staff who completed Resident #253's Recreation Assessment should have included the resident's activity preferences in the resident's care plan.

During an interview with the surveyor on 02/06/24 at 11:30 AM, the Director of Nursing (DON) stated that resident care plans are initiated upon admission and should include resident preferences. The DON further explained that care plans include the resident's needs in order to develop a plan of care with appropriate interventions. When asked about Resident #253, the DON stated the care plan should have included the resident's activity preferences.

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2. On 01/30/24 at 10:26 AM, the surveyor observed Resident #145 lying in bed. The resident complained of NJ Exec. Order 26:4.b.1 and stated he/she reported it to the facility staff.

On 02/02/24 at 10:53 AM, the surveyor observed Resident #145 sitting in a wheelchair in his/her room. The resident stated that he/she had been receiving medication from the nurse that had helped with the NJ Exec. Order 26:4.b.1. The resident also stated that he/she had NJ Exec. Order 26:4.b.1 and was waiting for the results.

According to the Admission Record, Resident #145 was admitted with diagnoses which included, but were not limited to, NJ Exec. Order 26:4.b.1

Review of the admission MDS, dated NJ Exec. Order 26:4.b, included the resident had a BIMS score of NJ Exec. Order which indicated the resident's cognition was NJ Exec. Order

Review of the Order Summary Report, as of NJ Exec. Order 26:4.b, included an order for NJ Exec. Order 26:4.b.1 of the NJ Exec. Order 26:4.b.1, dated NJ Exec. Order 26:4.b.1 Further review of the Order Summary Report included an order for NJ Exec. Order 26:4.b.1 as needed for NJ Exec. Order 26:4.b.1, ordered NJ Exec. Order 26:4.b, and NJ Exec. Order 26:4.b.1 y for NJ Exec. Order 26:4.b.1, ordered NJ Exec. Order 26:4.b.

Review of the Physician Note, dated NJ Exec. Order 26:4.b,

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F 656	Continued From page 9 included, under assessment/plan, NJ Exec. Order 26:4.b.1 Review of the Physicians Progress Note, dated NJ Exec. Order 26:4.b.1, included Resident #145 NJ Exec. Order 26:4.b.1 Review of the Physicians Progress Note, dated NJ Exec. Order 26:4.b.1, included Resident #145 NJ Exec. Order 26:4.b.1 and, NJ Exec. Order 26:4.b.1 Review of the care plan, initiated NJ Exec. Order 26:4.b, did not include the resident's risk for NJ Exec. Order 26:4.b.1 interventions. During an interview with the surveyor on 02/05/24 at 11:00 AM, the Licensed Practical Nurse (LPN) stated that care plans are initiated upon admission and includes resident treatments. The LPN further stated that care plans inform the staff about the care required for the resident. When asked about Resident #145, the LPN stated the resident complained of NJ Exec. Order 26:4.b.1, and the physician ordered NJ Exec. Order 26:4.b and NJ Exec. Order 26:4.b.1 The LPN then stated that since the resident was admitted with a diagnosis of NJ Exec. Order 26:4.b.1 and received treatment for the NJ Exec. Orde the resident's NJ Exec. Order 26:4.b.1 should have been included on the care plan. During an interview with the surveyor on 02/05/24 at 11:50 AM, the LPN/Unit Manager (LPN/UM) stated each department is responsible for updating the resident care plans and that care plans should include anything the resident requires interventions for. The LPN/UM further stated that care plans benefit the resident because staff can refer to them for the	F 656		

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appropriate interventions. When asked about Resident #145, the LPN/UM stated the resident complained [redacted] and the physician ordered [redacted] and medication to help with [redacted]. At that time, the LPN/UM checked the resident's care plan and acknowledged that it did not include the resident's [redacted]. The LPN/UM further stated she was unsure if the [redacted] should be included on the care plan, but that "it can be added on and probably will be."

During an interview with the surveyor on 02/05/24 at 9:10 AM, the MDS Coordinator (MDSC) stated UMs are responsible for initiating and updating the resident care plans which includes any ongoing problems or risks for problems the resident has. The MDSC explained that care plans should be initiated within 24-72 hours and be updated as soon as there are nay new changes to the resident's treatment. The MDSC further stated that the purpose of care plans were to be able to give proper care to the resident, prevent deterioration, and to refer to any special services. When asked about Resident #145, the MDSC stated the resident's diagnosis of [redacted] and the facility's management of [redacted] should have been included on the care plan.

During an interview with the surveyor on 02/06/24 at 11:30 AM, the Director of Nursing (DON) stated that resident care plans are initiated upon admission and should include the resident's diagnoses. The DON further explained that care plans include the resident's needs in order to develop a plan of care with appropriate interventions. When asked about Resident #145, the DON stated the resident's [redacted]

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should have been included on the care plan.

3. On 01/30/24 at 11:56 AM, Resident #301 was observed in bed, NJ Exec. Order 26:4.b.1. There was a private duty caregiver at the resident's bedside who stated that she was a live-in caregiver (LIC). The LIC stated that the resident NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 and had gotten NJ Exec. Order 26:4.b.1 when needed.

On 02/02/24 at 11:52 AM, Resident #301 was observed in a wheelchair accompanied by their son. The surveyor inquired with the son as to whether the resident was having NJ Exec. Or and the son stated, NJ Exec. Order 26:4.b.1 and stated that he/she would have made it verbally known if they had NJ Exec. Orde

According to the Admission Record, Resident #301 had diagnoses which included, but were not limited to, NJ Exec. Order 26:4.b.1

Review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated, NJ Exec. Order 26:4.b, included the resident had a Brief Interview for Mental Status score of NJ Exec. O which indicated that the resident NJ Exec. Order 26:4.b.1

Review of the Care Plan (CP), initiated NJ Exec. Order 26:4.b.1 did not include a resident's Focus for NJ Exec. Orde

Review of the Order Summary Report, dated Active orders as of NJ Exec. Order 26:4.b.1 revealed and order for NJ Exec. Order 26:4.b.1

Review of the Medication Administration Record,

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dated 01/01/2024-01/31/2024, revealed Resident #301 received NJ Exec. Order 26:4.b.1 on 01/23/24 at 0712 and again on 01/24/24 at 0713.

During an interview with the surveyor on 02/02/24 at 12:05 PM, the Certified Nursing Assistant (CNA) who was caring for Resident #301, stated that she would ask the resident if he/she had NJ Exec. O and they would respond by stating, NJ Exec. Order 26:4 The CNA stated that if the resident had NJ Exec. O that she would tell the nurse and she would also make sure the resident did not NJ Exec. Order 26:4.b.1."

During an interview with the surveyor on 02/05/24 at 11:03 AM, LPN #2 stated that a CP included interventions used for the residents as a part of their care. LPN #2 further stated that if a resident had pain that she would have expected to see pain management interventions on the CP.

During an interview with the surveyor on 02/05/24 at 11:25 AM, the Licensed Practical Nurse Unit Manager (LPN/UM #2) stated that she would have expected to see a Focus of pain on a CP for a resident that had fractures with the interventions to choose from. She stated that there was a pain template that could have been modified for a resident.

During an interview with the surveyor on 02/06/24 at 10:49 AM, the Director of Rehabilitation (DOR) stated that a CP was a snapshot of a resident and their needs and that every discipline was able to add to the CP their perspective from their discipline. The DOR stated that unless a resident complained of pain that she would not have expected to see a Focus of pain on the CP. The surveyor and the DOR reviewed Resident #301's CP together in the EMR and the DOR

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acknowledged that she did not see a NJ Exec. Order 26:4 NJ Exec. Or on the CP.

During an interview with the surveyor on 02/06/24 at 11:47 AM, the surveyor and LPN #2 reviewed Resident #301's CP together in the EMR and LPN #2 acknowledged that she did not see a NJ Exec. Order 26:4.b.1 on the CP and that she would have expected to have seen it. LPN #2 stated that it was important to include NJ Exec. Or on the CP because the interventions and goals were specific for each resident.

During an interview with the surveyor on 02/06/24 at 11:56 AM, the surveyor and LPN/UM #2 reviewed Resident #301's CP together in the EMR and LPN/UM #2 acknowledged that she did not see a NJ Exec. Order 26:4.b.1 on the CP. She stated that if a resident was NJ Exec. Order 2, that NJ Exec. Or should have been on the CP and that it was important that the NJ Exec. Or was addressed. LPN/UM #2 then stated, "I will put it in now."

During an interview with the surveyor on 02/06/24 at 12:11 PM, the Assistant Director of Nursing (ADON) stated that if a resident had NJ Exec. Order 26:4.b.1 that she would have expected to see NJ Exec. Or on the CP. The surveyor and the ADON reviewed Resident #301's CP together in the EMR and the ADON was made aware that the NJ Exec. Order 26:4.b.1 was added by LPN/UM #2 after surveyor inquiry.

During an interview with the surveyor on 02/06/24 at 12:19 PM, the DON stated that if a resident had NJ Exec. Order 26:4.b.1 that she would have expected to see NJ Exec. Or on the CP. The surveyor and the DON reviewed Resident #301's CP together in the EMR and the DON was made

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aware that the [redacted] was added by LPN/UM #2 after surveyor inquiry.

During an interview with the surveyor on 02/06/24 at 12:27 PM, the MDSC acknowledged that if a resident had a diagnosis [redacted] that she would have expected to see [redacted] on the CP.

On 02/06/24 at 03:39 PM, the surveyors met with the administration team and the surveyor discussed concerns about Resident #301's [redacted] not being addressed on a CP and that it was added after surveyor inquiry.

On 02/07/24 at 11:19 AM, the surveyors met with the administration team and the Regional Nurse (RN) stated that a full house pain CP audit was completed and that every resident that had a pain assessment with a pain CP, and in-services were completed.

Review of the facility's Comprehensive Care Plans policy, undated, included, "1. The care planning process will include an assessment of the resident's strengths and needs...2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment ... Other factors identified by the interdisciplinary team, or in accordance with resident's preferences, will also be addressed in the plan of care," and, "The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the highest practicable physical, mental, and psychosocial well-being...f. Resident specific interventions that reflect the resident's needs..."

Review of the facility's Pain Assessment and

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F 656	Continued From page 15 Management policy, revised October 2022, included, "Defining Goals and Appropriate Interventions. 1. The pain management interventions are consistent with the resident's goals for treatment which are defined and documented in the care plan." NJAC8:39-11.2 (e)(f)	F 656		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to provide a resident with meaningful activities that reflected the resident's preferences for 1 of 1 resident (Resident #253) reviewed for activities. This deficient practice was evidenced by the following: On 01/30/24 at 10:39 AM, the surveyor observed Resident #253 sitting in a wheelchair in his/her room. The resident stated that he/she would like	F 679	1.Resident 253 is no longer at the facility. This resident was given a calendar and activity care plan was completed. Activity calendars placed in each resident's room on resident's unit as well as outside main living area and at the entrance of the Unit. Resident was invited to attend activities during remainder of her stay. 2.All residents may be affected by not having a completed care activity care plan. All residents were reviewed to ensure all have activity care plans.	3/15/24

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F 679	Continued From page 16 to go to activities, but that there is no one to take him/her. On 02/01/24 at 9:45 AM, the surveyor sat in the lounge outside of Resident #253's room. There was an Activities Calendar on the table in the lounge that included a 10:00 AM sing-along activity. The calendar did not indicate where the activity was located. At 10:15 AM, the surveyor did not observe any sing-along activities on the unit, and staff did not enter the resident's room to offer to take her to an activity. Further review of the Activities Calendar included a 10:45 AM Communion activity. At 10:49 AM, the surveyor was still seated in the lounge and did not observe any Communion activity on the unit or staff offering to take the resident to the activity. At 10:51 AM, the surveyor observed a visitor enter the resident's room. When the surveyor entered the resident's room, the visitor identified him/herself as the resident's family member. When asked if the resident was offered to attend the sing-along or the Communion, the resident's family member asked the resident who stated, "no." The resident's family member further stated that those would have been activities the resident would have attended. According to the Admission Record, Resident #253 had diagnoses which included, but were not limited to, NJ Exec. Order 26:4.b.1 [redacted] Review of the admission 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	F 679	3.A member of the recreation staff will make daily visits to the residents and inform them of the daily activities. Residents can alert the staff member at that time, or a nurse/CNA later that day, of their interest in attending that activity. Recreation Director or her designee will complete activity attendance audit weekly. Recreation Department staff and Nursing Staff in-serviced on the new process on 2-6-24. 4.Recreation Director will review audits monthly and will report to Quality Assurance performance Improvement Committee quarterly for 6 months.	

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F 679	Continued From page 17 Status score of [NJ Exec. Order 26:4.b.1] which indicated the resident's cognition was [NJ Exec. Order 26:4.b.1]. Further review of the MDS included it was very important to the resident to [NJ Exec. Order 26:4.b.1] and, [NJ Exec. Order 26:4.b.1] Review of the Recreation Assessment, dated [NJ Exec. Order 26:4.b.1], included [NJ Exec. Order 26:4.b.1] Review of the care plan, initiated [NJ Exec. Order 26:4.b.1] included the resident had a [NJ Exec. Order 26:4.b.1] with an intervention that [NJ Exec. Order 26:4.b.1] The care plan did not include the resident's preferences for activities or interventions to ensure the resident's activity preferences are met. During an interview with the surveyor on 02/01/24 at 10:55 AM, the Certified Nursing Assistant (CNA) stated that there were no activities offered on the first floor subacute unit and that the calendar posted indicated the activities offered on the second floor units. The CNA further stated that if a resident needed assistance getting to and from an activity, the activities staff would assist the resident. The CNA added that it was important for residents to attend activities to prevent boredom and provide socialization. When asked about Resident #253, the CNA stated the resident does not attend activities. During an interview with the surveyor on 02/01/24 at 11:00 AM, the Licensed Practical Nurse (LPN) stated there were no specific activities on the subacute unit and if residents needed help going	F 679		

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to and from an activity, the resident should have notified the staff. The LPN further stated that activities were important so that residents felt more at home. When asked about Resident #253, the LPN stated that he/she attends [NJ Exec. Order 26:4.b] and the nursing staff place him/her in the lounge to watch television.

During an interview with the surveyor on 02/01/24 at 11:08 AM, the LPN/Unit Manager (LPN/UM) stated that the activities calendar posted on the subacute unit informs the residents of activities available on the second floor and that if residents needed assistance getting to and from the activity, the nursing or activity staff would assist the resident. The LPN further stated that activities were important because they provided stimulation, distraction, and socialization. When asked about Resident #253, the LPN stated the resident required NJ Exec. Order 26:4.b.1 with activities of daily living and that staff could have assisted the resident with going to activities.

During an interview with the surveyor on 02/01/24 at 11:52 AM, the Activities Director (AD) stated that the activities staff completed an initial assessment when residents were admitted to determine their activity preferences.

During an interview with the surveyor on 02/01/24 at 12:10 PM, the Assistant Activities Director (AAD) stated that every resident was assessed for activity preferences upon admission to the facility. The AAD further stated she completed the resident's Recreation Assessment, and that Resident #253 was NJ Exec. Order 26:4.b.1 was available for the resident to attend. The AAD also stated she was unsure if staff assisted the resident with attending activities, but that staff

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F 679	Continued From page 19 should have offered to take the resident to activities as long as there were no schedule conflicts with NJ Exec. Order 26:4.b.1. During an interview with the surveyor on 02/06/24 at 11:30 AM, the Director of Nursing (DON) stated upon admission, the activities staff assess the resident to determine what activities the resident enjoys. The DON further stated that residents on the subacute unit have to attend activities on separate units. The DON added that nursing or activities staff will assist residents to and from the activities if needed and that activities are important for the residents' psychosocial wellbeing. When informed about Resident #253 missing activities that he/she would have liked to participate in, the DON stated that the CNAs on the unit are familiar with the resident's routine and should have taken him/her to the activities. Review of the facility's undated Activities policy, included, "It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being." Further review of the policy included, "All staff will assist residents to and from activities when necessary." NJAC 8:39-7.3(a)	F 679		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		3/15/24

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F 686	Continued From page 20 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Complaint #NJ168566 Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to a.) ensure a pressure reducing device was used correctly and b.) failed to provide care and services consistent with professional standards of practice to promote the prevention of pressure ulcer/injury development specifically by not providing protective boots to heels as ordered. This deficient practice was identified for two (2) of four (4) residents (Resident #3 and #104) reviewed for NJ Exec. Order 26:4.b.1 . This deficient practice was evidenced by the following: 1. On 1/30/24 at 11:57 AM, during the initial tour, Resident #104 was not in their room. A staff member identified Resident #104 in the dayroom,	F 686	1.Resident # 104 and resident # 3 orders and care plans reviewed and updated. Towel removed from resident # 104 wheelchair placed by hospice aide and nurse completed a NJ Exec. Order 26:4.b.1. The hospice aide in-serviced on reasons not to cover seat cushion. NJ Exec. Order 26:4.b.1 completed for resident # 3 and NJ Exec. Order [redacted] applied. Extra NJ Exec. Order 26:4.b.1 ordered. Education provided to all staff including support staff. 2.All residents may be affected by this practice of placing a towel or barrier over a wheelchair cushions. All residents having an order for heel protectors may be affected by nursing not applying heel protectors as ordered. 3.Unit Managers to complete rounds and will complete audits weekly and check for any towels or barriers placed on wheelchairs. All nurses, CNAs, and	

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F 686	Continued From page 21 sitting in a NJ Exec. Order 26:4.b.1 of the wheelchair. The surveyor reviewed the medical record for Resident #104. According to the Admission Record (AR), Resident #104 had diagnoses which included: NJ Exec. Order 26:4.b.1 A review the annual Minimum Data Set (MDS), an assessment tool, dated NJ Exec. Order 26:4.b, reflected the Brief Interview for Mental Status (BIMS) score was NJ Exec. Order 26:4.b.1. A review in Section H - Bladder and Bowel indicated the resident was NJ Exec. Order 26:4.b.1. A review in Section M - Skin condition revealed the resident was NJ Exec. Order. A further review indicated the resident NJ Exec. Order 26:4.b.1 A review of the individualized comprehensive care plan (ICCP) included a focus area, dated NJ Exec. Order 26:4. for NJ Exec. Order 26:4.b.1 Interventions included to NJ Exec. Order 26:4.b.1 A review of the skin assessments from NJ Exec. Order 26:4.b	F 686	hospice aides in-serviced. All residents with an order for heel protectors reviewed. Unit Managers will audit residents with an order for heel protectors weekly to ensure heel protectors applied as ordered. 4.Director of nurses or designee will view audits monthly and will submit findings quarterly to Quality assurance performance Improvement Committee.	

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F 686	Continued From page 22 to [NJ Exec. Order 26:4.b], indicated that the resident's [NJ Exec. Order 26:4.b] [redacted] On 02/01/24 at 10:24 AM, the surveyor observed Resident #104 in the dayroom sitting in a [NJ Exec. O] [redacted] At that time, the surveyor observed the resident seated on a [NJ Exec. Order 26:4.b] [redacted], which was a [NJ Exec. Order 26:4.b.1] [redacted], that was directly underneath the resident. On 02/01/24 at 01:04 PM, the surveyor observed Resident #104 in the dayroom sitting in a [NJ Exec. O] [redacted] At that time, the surveyor observed the resident was still seated [NJ Exec. Order 26:4.b] [redacted] that was directly underneath the resident. On 02/02/24 at 10:41 AM, the surveyor observed Resident #104 in the dayroom sitting in a [NJ Exec. O] [redacted]. At that time, the surveyor observed the resident seated on [NJ Exec. Order 26:4.b.1] [redacted] that was directly underneath the resident. On 02/05/24 at 10:28 AM, the surveyor observed Resident #104 in the dayroom sitting [NJ Exec. Order 26:4.b] [redacted]. At that time, the surveyor observed the resident seated on [NJ Exec. Order 26:4.b.1] [redacted] that was directly underneath the resident. On 02/05/24 at 10:29 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) who stated that she rounded on her residents every 2 hours and more frequently if needed. CNA #1 stated that most of the residents sat in the dayroom/dining room so staff would monitor the residents on the comfort care (dementia) unit.	F 686		

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When asked if she placed anything underneath the residents while they were sitting in the chairs? CNA #1 stated that she did not personally put anything underneath her residents unless the resident was in the bed then she would put a "blue chuck" (pad) underneath the resident. CNA #1 then stated that "if you put something underneath the resident it could damage their skin." She further stated that she felt that some CNAs placed towels underneath residents because it was a way of being "lazy", so they did not have to toilet the resident frequently. CNA #1 then stated that the towel could have been used to prevent the resident from sliding and slipping out of their chair. She concluded that instead of putting a towel or blanket underneath a resident they could have gotten another cushion to prevent residents from sliding.

On 02/05/24 at 10:35 AM, the surveyor interviewed CNA #2 who stated that she was caring for Resident #104 today (2/5/24). CNA #2 stated that she rounded on her residents when she first came in, after breakfast and then frequently throughout the day. She stated that the staff was very helpful and assisted her if she needed anything, because she was from an agency. When asked if she would put anything underneath the resident for those that needed to be toileted more frequently, CNA #2 stated that sometimes she would put a "bath blanket" underneath the resident but not a towel because the bath blanket was softer. She further stated that some cushions were "plastic" and the "bath blanket" was a barrier for comfort. CNA #2 emphasized that it was not to absorb anything but more of a cushion and comfort for the resident. She explained that a towel should not be underneath the resident because if a resident

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SEASHORE GARDENS LIVING CENTER	22 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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was sitting on it for a long period of time it could cause skin irritation and the goal was to prevent skin breakdown. CNA #2 stated that most of the resident's skin were fragile, and that staff needed to be mindful and ensure the resident was comfortable. CNA #2 stated that Resident #104 was on hospice and that the hospice aide came and provide morning care, dressed the resident, assisted with breakfast, and placed the resident in the wheelchair this morning.

On 02/05/24 at 10:55 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that staff rounded on the resident every hour. She further stated that if a resident needed to be toileted more frequently then they ensured that the resident was toileted more often. When asked if they would put anything underneath the resident, LPN #1 stated that they did not put anything underneath the resident because if they allowed urine to soak if could cause skin break down. She explained if the resident had a cushion seat, then they still should not place anything on top of the cushion directly underneath the resident because it could have caused skin breakdown. LPN #1 stated that Resident #104 was NJ Exec. Order 26:4.b.1 and currently did not have NJ Exec. Order 26:4.b.1. At that time, the surveyor and LPN #1 walked over to Resident #104 sitting in their NJ Exec. Order 26:4.b.1 [redacted] LPN #1 confirmed Resident #104 was sitting directly on NJ Exec. Order 26:4.b.1 [redacted]. She acknowledged the resident should not have been sitting on the blanket. LPN #1 stated that the hospice aide got the resident up in the morning but that if someone had seen the blanket that they should have removed it. LPN #1 concluded they should remove the blanket to prevent NJ Exec. O[redacted]

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NJ Exec. Order 26:4.b.1 [redacted]

On 02/05/24 at 11:04 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) for the comfort care unit who stated that the residents in wheelchairs were provided seat cushions which helped prevent skin breakdown. The LPN/UM stated that the therapy department provided a blue gel pad that was placed underneath the seat cushion to prevent the resident from sliding. When asked if they placed anything on top of the cushion the LPN/UM stated that the resident should not have anything like a towel or blanket directly underneath them. She explained that the towels could have slid and it "would not be conducive for the residents skin integrity." At that time, the surveyor and the LPN/UM walked over to Resident #104. The LPN/UM confirmed the resident was sitting directly on NJ Exec. Order 26:4.b.1 [redacted] She then stated that the resident should not have had the blanket directly underneath them as it was not normal procedure.

On 02/05/24 at 11:11 AM, the surveyor observed staff remove the blanket from underneath Resident #104.

On 02/05/24 at 11:42 AM, the surveyor interviewed the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team. The DON stated that the unit managers, the nurses, and the CNAs should round on their residents as soon as they started their shift. She further stated that the CNAs should have rounded on their residents at least every 2 hours and more often as needed. When asked if the staff needed to put

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anything underneath the resident that needed to be toileted frequently the DON stated it was "very rare if you see the staff placing the chucks underneath the resident," which was used on the beds to prevent anything penetrating the sheets. The DON then stated that sometimes the staff used a towel or blanket to prevent residents from sliding. The DON then acknowledged they should not be placing a towel or blanket directly underneath the resident. At that time, the LNHA confirmed that staff should not have a towel of blanket on top of the cushion and should not be underneath as a barrier for residents that were incontinent. The LNHA then stated that a towel or blanket should only be placed underneath a resident if the resident or resident's representative requested it, and it was care planned for it. The LNHA acknowledged that the towel and blanket should not have been directly underneath the resident because it could have compromised the resident's skin integrity.

On 02/05/24 at 12:05 PM, the LNHA stated in the presence of the survey team that she went to the comfort care unit and the LPN/UM informed her that it was the hospice aide that had placed the blanket underneath the resident because "she thought to make the resident more comfortable."

On 02/07/24 at 09:49 AM, the surveyor interviewed the Director of Rehab (DOR) who stated that every resident with a wheelchair had the blue gel pad placed directly underneath the cushion to prevent the resident from sliding out of the chair. The DOR stated that the purpose of the cushion was for additional support, to prevent any skin breakdown, wounds and for comfort. She stated that there should not have been a towel or blanket on top of the cushion because the

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resident could have slid, and it was not supportive. The DOR emphasized another layer should not have been between the resident and the cushion. She then stated that some residents do request it, but they should be care planned as a preference.

On 02/07/24 at 11:27 AM, Regional Nurse #1 stated in the presence of the Licensed Nurse Home Administrator (LNHA), the Director of Nursing (DON), Regional Nurse #2, the Regional LNHA and the survey team that items such as a towel and blanket should not be placed directly underneath the resident because it increased the risk for falls and skin integrity issues. She further stated that "you are not getting the benefit of the cushion if you are putting something on top of the cushion."

b.) On 02/01/2024 at 10:01 AM, the surveyor observed Resident # 3 in his/her room. At that time, Resident # 3 did not have NJ Exec. Order 26:4.b.1 . During this time, he/she said they do not get NJ Exec. Order 26:4.b.1 put on him/her.

On 02/05/2024 at 10:48 AM, the surveyor observed Resident # 3 in his/her room. At that time, Resident # 3 did not have NJ Exec. Order 26:4.b.1

On 02/05/2024 at 11:16 AM during an interview with the surveyor, Licensed Practical Nurse #2 confirmed an order for NJ Exec. Order 26:4.b.1 appeared in the orders in the Electronic Medical Record (EMR).

On the same date at 11:20 AM, during an interview with the surveyor, CNA # 3 assigned to Resident # 3 said that NJ Exec. Order 26:4.b.1 were

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not in Resident # 3's room.

On the same date at 11:37 AM, during an interview with the surveyor while in Resident # 3's room, the Registered Nurse/Unit Manager (RN/UM # 1) observed that the resident did not have NJ Exec. Order 26:4.b.1 on. At that time, RN/UM # 1 stated that the order could have been transcribed improperly. She concluded by saying she will make sure it appeared on the nurse's end.

On 02/06/2024 at 4:00 PM during an interview with the surveyor, the Director of Nursing (DON) replied, "Yes" when asked by the surveyor if a resident had an order for NJ Exec. Order 26:4.b.1 to be NJ Exec. Order 26:4.b.1 every shift, should they have been placed on the resident's NJ Exec. Orde while they were in bed. The DON concluded by replying, "NJ Exec. Order 26:4.b.1" when asked by the surveyor what potential results could have occurred if the NJ Exec. Order 26:4.b.1 were not NJ Exec. Orde according to the order.

A review of the EMR for Resident # 3 revealed a physician's order for NJ Exec. Order 26:4.b.1 for every shift that was revised on NJ Exec. Order 26:4.b.1 and discontinued on NJ Exec. Order 26:4.b.1 at 11:24 AM.

A review of the paper-chart for Resident # 3 revealed a telephone order sheet dated NJ Exec. Order 26:4.b.1 that revealed, NJ Exec. Order 26:4.b.1 An initial and hand-written statement revealed, "Noted NJ Exec. Order 26:4" adjacent to the order.

A review of the facility's policy "Pressure Injury Prevention and Management revised 7/25/22, included, "4. Interventions for Prevention and to promote healing c.i. Redistribute pressure (such

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F 686	Continued From page 29 as repositioning, protecting and or offloading heels, etc.), iii. Provide appropriate, pressure re-distributing, support surfaces, iv. Provide non-irritating surfaces."	F 686		
F 689 SS=D	N.J.A.C. § 8:39-27.1 (a) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint #NJ168222 and NJ168566 Based on observation, interview, and record review it was determined that the facility failed to ensure an environment was free from accident hazards by failing to place assistive devices, specifically NJ Exec. Order 26:4.b.1, to prevent avoidable accidents for 1 of 7 residents (Resident # 97) investigated for Accidents. The deficient practice was evidenced by the following: On 01/30/2024 at 10:55 AM, during the initial tour of the facility, the surveyor observed Resident # 97 in their room in bed. The surveyor observed two NJ Exec. Order 26:4.b.1 folded and leaning against the wall on either side of the room. At that time,	F 689	1.Resident #97 was assessed and there was no negative outcome. The NJ Exec. Order 26:4 were in place as indicated in the plan of care. Nurses to sign off every shift that NJ Exec. Order 26:4.b.1 are in place. 2.All current residents at risk for falls were identified and reviewed to ensure all safety precautions/interventions were followed as reflected in the plan of care. 3.All fall incidents will be reviewed during clinical meetings with the IDCP team to ensure interventions are added/updated along with the date initiated. The ADON, Unit Managers and Supervisors will educate the nursing staff on the units of the new interventions to help prevent falls	3/15/24

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F 689	Continued From page 30 Resident # 97 replied, "They haven't used them." when the surveyor asked if the facility had used the [NJ Exec. Order 26:4.b.1] while he/she was in bed. On 02/05/2024 at 09:46 AM, the surveyor observed Resident # 97 in their room in bed. The surveyor observed the two [NJ Exec. Order 26:4.b.1] folded and leaning against the wall on either side of the room. At that time, Resident # 97 replied, "No" when the surveyor asked if the facility had used the [NJ Exec. Order 26:4.b.1] while he/she was in bed. A review of Resident # 97's Minimum Data Set (an assessment tool) dated [NJ Exec. Order 26:4.b.1] revealed under section "J" that he/she [NJ Exec. Order 26:4.b.1] in the last month prior to admission. A review of Resident # 97's Electronic Medical Record (EMR) revealed under "Orders," a physician's order for [NJ Exec. Order 26:4.b.1] while in bed every shift. The order was started on [NJ Exec. Order 26:4.b.1]. A review of Resident # 97's EMR revealed under "Care Plan" a focus for [NJ Exec. Order 26:4.b.1] related to [NJ Exec. Order 26:4.b.1] and [NJ Exec. Order 26:4.b.1]. The focus revealed an initiated date of [NJ Exec. Order 26:4.b.1]. The care plan revealed an intervention for [NJ Exec. Order 26:4.b.1] at bedside. The intervention revealed an initiated date of [NJ Exec. Order 26:4.b.1] On 02/05/2024 at 09:54 AM, during an interview with the surveyor, the Registered Nurse/Unit Manager (RN/UM #1) replied, "Yes. [He/She] should have them [NJ Exec. Order 26:4.b.1]." At the time of the interview the surveyor showed RN/UM #1 the [NJ Exec. Order 26:4.b.1] placed against the walls in Resident # 97's room.	F 689	and injuries. The DON/Designee will conduct audit observations monthly to ensure plan of care is being followed as indicated. 4.The DON/Designee will conduct audits on all residents identified with fall incidents □ care plans monthly times three months to ensure interventions on the plan of care are being implemented and followed accordingly. The DON/Designee will report all care plan interventions findings to the resident safety committee and to Quality Assurance Performance Improvement Committee quarterly for further review and recommendations as indicated.	

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F 689	Continued From page 31 On 02/06/2024 at 4:00 PM, during an interview with the surveyor, the Director of Nursing said the NJ Exec. Order 26:4.b.1 should not have been folded against the wall. During the same interview, the Regional Nurse #1 replied, "Injury could occur" when the surveyor asked what potential results could have occurred if the NJ Exec. Order 26:4.b.1 were not placed according to the order. A review of the facility policy titled, "Comprehensive Care Plans" with a copyright date of 2023, revealed under subsection, "Policy Explanation and Compliance Guidelines" number 3. letter "a." that, "The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being." § 8:39-27.1 (a)	F 689		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure the medication error rates are not 5 percent or greater. This deficient practice was identified for 2 of 5 residents (Resident #143 and Resident #147), and 1of 2 nurses on the second-floor nursing unit during the Medication Administration task.	F 759	1.Resident #143 and # 147 was assessed and evaluated and there was no negative outcome. Both nurses were re-educated on proper medication administration and following medication cautionaries of administrating medication with food or meal. On 2/6/24 full in-house audit completed and orders updated for medications with food/meals completed	3/15/24

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F 759	Continued From page 32 The deficient practice was evidenced by the following: On 02/01/2024 at 08:55 AM, during the medication administration, the surveyor observed the Licensed Practical Nurse (LPN) prepare and administer medications to Resident #143 which included NJ Exec. Order 26:4.b.1 [redacted]. That medication had a pharmacy label on the package which instructed to "give with food." The surveyor observed Resident #143 in their room as the LPN administered the medication. At that time, the surveyor did not observe any food available in the vicinity of the resident. The LPN did not offer the resident any food with the medication. On 02/01/2024 at 09:00 AM, during the medication administration, the surveyor observed the LPN prepare and administer NJ Exec. Order 26:4.b.1 [redacted] to Resident #147. That medication had a pharmacy label on the package which instructed to "give with food." The surveyor observed Resident #147 in their room as the LPN administered the medication and the LPN did not offer the resident any food with the medication. The surveyor observed a covered meal tray next to the resident. The LPN did not ask the resident if he/she ate their breakfast. On 02/01/2024 at 09:06 AM, the surveyor interviewed the LPN once she returned to the medication cart. The surveyor inquired as to what the policy was about medications that say to take with food. The LPN responded, "I try to give meds	F 759	and plotted for appropriate times. 2.All residents with an order for a medication to be taken with a meal/food may be affected. Full House Audit of current residents will be completed by unit managers of medication orders to be taken with food or meal as specified by manufacturer. 3.The DON or designee will re-educate all Licensed staff on Medication administration policy and Procedures with emphasis on administering of medication with specific cautionaries. In-service completed on on 2/13/24. 4.The DON/designee will audit weekly X 4 then Monthly X 2 until sustained compliance is achieved. All findings will be presented to the pharmacy committee meeting for analysis and recommendations and to Quality Assurance Performance Improvement quarterly.	

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[medications] to them around breakfast time. The trays come up [to the floor] at 8:35am. I saw the aides delivered trays. There are also snacks in the bottom drawer cart that we can offer with meds." At that time, when the LPN opened the bottom drawer of the medication cart, the surveyor observed no snacks in the drawer.

On 02/06/2024 at 04:04 PM, during an interview with the Director of Nursing (DON) and Reginal Nurse #2, the surveyor inquired as to the expectation when medications were marked to take with food. The DON replied, "It should be taken with food, no crackers or cookies, it should be a meal." When the surveyor inquired as to whether the nurses should have assumed that the residents ate breakfast because they saw the food trays had been delivered, the Regional Nurse #2 responded, "They should ask the resident or look at the resident's tray, they should not assume."

Review of Resident #143's Admission Record reflected the resident was admitted to the facility with diagnosis which included but was not limited to NJ Exec. Order 26:4.b.1 [redacted]

Review of Resident #143's Physician Order Summary (POS) included an order for NJ Exec. Order 26:4.b.1 [redacted] he POS also included an order for NJ Exec. Order 26:4.b.1 . The order specified to give NJ Exec. Order 26:4.b.1 [redacted] to be administer with

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F 759	Continued From page 34 food. Medication should be swallowed whole. Do not crush, chew or open capsules. The order for the medication revealed a start date of [redacted] NJ Exec. Order 26:4.b.1 Review of the facility's policy, "Medication Administration," updated on 05/30/23, revealed under the subsection titled, "Policy Explanation and Compliance Guidelines," #14 "Administer medication as ordered in accordance with manufacturer", "a. Provide appropriate amount food and fluid." N.J.A.C 8:39-29.2(d)	F 759		
F 761 SS=D	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 §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. §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	F 761		3/15/24

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SEASHORE GARDENS LIVING CENTER	22 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 35 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to maintain medications with appropriate dating of medications for 1 of 3 medication administration carts inspected and was evidenced by the following: On 01/31/24 at 10:43 AM, the surveyor inspected the medication storage cart labeled Cart A on the 2 (two) North Unit with the Licensed Practical Nurse (LPN). The surveyor identified that there was an undated opened foil package containing 17-unit dose vials of the medication Ipratropium Bromide/Albuterol (DuoNeb) used for nebulizer treatments. The surveyor interviewed the LPN at the time of the inspection who confirmed that the medication should have been dated when opened because the medication was only good for two weeks after the foil package was opened. On 01/31/24 at 10:53 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) for 2 North who stated that medications should have been dated when they were opened because some medications, once opened, expired quicker than other medications. The LPN/UM confirmed that all medications that were on the list of short expiration medications should have been dated when opened and that the nurse could have referred to this list if there were any questions regarding the expiration of	F 761	1.The package of undated Ipratropium Bromide/Albuterol (Duoneb) was discarded upon surveyor discovery. 2.All residents with these treatments may be affected by not properly dating opened medications. 3.Full facility audit conducted on all unit medication carts and medication storage to check the status of any medications opened are dated according to the manufacturers shelf-life recommendations. Re-education provided to all licensed staff on protocol for dating medications after opening as well as review of medication storage policy. Pharmacy consultant will reinforce policy during monthly pharmacy regimen audit. 4.DON/Designee will continue to conduct audit weekly times 2, then monthly times 3 on medication cart, dating of opened medication, and expiration. Results of findings will be presented to Pharmacy Committee and to Quality Assurance Performance Improvement quarterly for further review and recommendation as indicated.	

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F 761	Continued From page 36 medications. She added that the list of short expiration medications was in a book on the medication carts. The surveyor reviewed the list, located on the medication cart, titled, "Pharma Accurate". The list contained the medication Ipratropium Bromide/Albuterol (DuoNeb) and indicated that the medication should have been discarded 7 to 14 days once removed from the foil package. On 01/31/24 at 01:05 PM, the surveyor interviewed the Pharmacy Consultant (PC) who stated that medications with short expiration dates must be dated when opened so that the nurses would have known when the medication would expire from that date. The PC confirmed that Ipratropium Bromide/Albuterol (DuoNeb) expired two weeks after the foil package was opened and that it should have been dated as soon as the nurse opened the foil package. The facility policy titled, "Medication Storage" indicated that it was the policy of the facility to ensure all medications houses on the premises will be stored in the pharmacy and/or storage rooms according to the manufactures recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. NJAC 8:39-29.4(a)	F 761		
F 800 SS=E	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that	F 800		3/15/24

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F 800	Continued From page 37 meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and review of facility documentation, it was determined that the facility failed to properly execute its food and nutrition services by not following the established portion control procedure. This deficient practice was evidenced by the following: On 01/30/24 at 11:17 AM, the surveyor interviewed the Director of Dietary (DD) who stated that the facility utilized a four week cycle menu and that they were in week three. On 02/05/24 at 12:22 PM, in the presence of the DD, the surveyor observed the cook at the steam table plating food for the lunch meal. The cook was wearing a hair covering, surgical mask and gloves. The cook was observed to use the food scoop and tongs to plate the food, rested her hands on the counter, used the scoop and tongs again, then used her gloved hand to remove whole green beans from the steam table and placed them on a plate, rested her hands on the counter, touched the front of her surgical mask, then used the scoop to plate food again. On 02/02/24 at 12:24 PM, the surveyor interviewed the cook who stated her role was to get the plate, place the food that was called out on to the plate, and then pass it to the dietary aide. The cook was made aware of the surveyor's observation when she used her hands to serve	F 800	1.All staff in-serviced on the proper serving sizes of all foods and what are the proper serving utensils. New serving utensils purchased to ensure proper equipment is on hand. Staff in-serviced about the policies documentation of maintaining a sanitary tray line, the cooks job description and duties, and hand washing/cleaning and cross contamination. 2.All residents may be affected by not using the proper food measuring utensil and by dietary staff not following policies on maintaining a sanitary tray line. 3.Director of Dietary reviewed all master menus to ensure that the amount is correct and legible to stay in proper guidelines. All dietary staff completed in-services on the above topics. The above items were added to weekly kitchen audit form. The tray line is to be checked daily to ensure proper serving utensils are being used. Handwashing audits to be completed weekly by Director of Dietary and /or her designee. 4.The kitchen weekly kitchen audits will be reviewed monthly by the Dietary Director and reviewed quarterly by Infection Control Committee and to QAPI committee for 6 months.	

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F 800	Continued From page 38	F 800		

the green beans. The cook acknowledged that she should not have used her hands to serve the food and stated that she was in a hurry and trying to get the food out of the kitchen. The cook stated that it was important to use the utensils to serve the food to prevent cross contamination. The surveyor inquired as to the portion size that was served on each plate and the cook stated, "the scoop is four ounces."

On 02/05/24 at 12:28 PM, the surveyor interviewed the DD who acknowledged that the cook plated the green beans with her hands. The DD stated that the cook should not have used her hands and that she should have used the tongs to serve the vegetables. The DD stated that it was important to use the scoop because it was a four-ounce (oz) measure for portions and that the portion sizes were established guidelines. The surveyor inquired that if the cook used her hands to serve the food how would she have known the portion size. The DD stated the cook did not know the portion size with her hands and that the scoop was accurate. The DD acknowledged that the use of hands to serve the food did not ensure an accurate four oz portion and that the cook would not have known the portion size using the tongs either. The DD stated that the cook should have used the scoop or spoodle (perforated measured spoon) to serve the green beans.

On 02/05/24 at 01:07 PM, the surveyor interviewed the cook and inquired as to whether she knew what portion size to serve on meal trays. The cook stated that everyone got the same portion or if she was told it was a double portion that they would get double the protein. The cook stated that she knew what a portion size was because she had "been doing this a

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long time." When the surveyor inquired about the portion size using her hands, the cook stated that it was "the same as the tongs, my finger is just as long as the tong." The cook further stated that it was important to make sure the portion size was correct because she wanted to give the residents enough food to eat and that she did not want them to go hungry.

On 02/06/24 at 11:30 AM, the surveyor interviewed the Corporate Registered Dietician (CRD) who stated she was NJ Exec. Order 26:4.b.1 [redacted] in the facility. The CRD stated that portion sizes were determined, and most facilities would use a scoop and that it would have depended on whatever the menu extension was. The CRD was unable to speak to where the portion size information came from and who made the menu. The CRD stated that the cook should have used whatever scoop was indicated for that item. She stated that whatever company the facility used that they would use the menu extensions and serving sizes from their menu. The CRD stated, "Usually whatever company comes in will have a Registered Dietician from that company that develops the menu."

On 02/06/24 at 04:09 PM, the administration team was made aware of the kitchen concerns. At that time, the surveyor interviewed the Regional Nurse (RN) about meal portion sizes. The surveyor inquired as to what the expectation was for kitchen staff to accurately portion the food. The RN stated the cook should not have used her hands but should have used the appropriate scoops, spoodle, ladle, or premeasured devices to ensure the proper nutritional caloric intake of each resident. During

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F 800	Continued From page 40 the interview with the RN, the Regional Licensed Nursing Home Administrator stated the importance of accurate food portioning was adequate nutrition and intake for the resident. A review of the facility documentation, "Week 4" menu, dated 11/29/23, revealed the menu on 02/05/24 included Seasoned Green Beans. A review of the facility documentation, "Master Menu, September 2023, Week: 4, Day: MONDAY," revealed under MENU ITEM in the LUNCH column was Green Beans, and the portion size listed under the REGULAR column was ½ cup. A review of the facility documentation, "Operations Policy and Procedure Manual Job Descriptions: Cook," revised 2/25/2008, revealed Duties and Responsibilities: Dietary Service: 3. Serve food in accordance with established portion control procedures. A review of the facility policy, "Maintaining a Sanitary Tray Line," revised 3/2023, revealed Compliance guidelines: 3. During tray assembly, staff shall: b. Use utensils such as tongs, serving spoons, etc. to handle food as much as possible. NJAC 8:39-17.2(a); 17.4(a)(3)	F 800		
F 812 SS=E	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,	F 812		3/15/24

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F 812	Continued From page 41 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 by: Based on observation, interviews and review of facility documentation it was determined that the facility failed to a.) properly handle and store potentially hazardous foods in a manner that is intended to prevent the spread of food borne illnesses and b.) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination, and c.) maintain adequate infection control practices during food service in the kitchen. This deficient practice was observed and evidenced by the following: On 01/30/24 at 10:01 AM, the surveyor arrived in the kitchen and was informed by the Cook that the Director of Dietary (DD) was not on location. At 10:06 AM, in the presence of the Cook, the surveyor toured the kitchen and observed the following: 1. On a rolling metal rack in the dairy refrigerator,	F 812	1.All opened, exposed or undated items were immediately discarded, staff in-serviced on the proper storage and labeling and dating of food products and the proper rotation and inspection of food for dates. Dented cans were immediately removed to the dent can area and the mixer was cleaned and covered. 2.All residents may be affected by not storing, preparing, distributing and serving food in accordance with professional standards for food service safety. 3.Staff was in-serviced on our dented can policy and in-serviced on the cleaning and covering items when not in use including paper products. Items were added to kitchen audit form and the Dietary Director and/or her designee will audit weekly. 4.The Dietary Director and/or her designee will report finding to infection	

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F 812	Continued From page 42 there were four trays containing oval tan patties, that the Cook identified as hash browns, that were uncovered with no label or dates. The Cook acknowledged the trays should have been covered, labeled and dated. There was one 3.5 pound (lb) opened package of lox that was wrapped in clear plastic wrap with no open or use by date. The Cook stated that he did not know when it was opened and that it should have had a label marked when it was opened. The Cook stated it was important to make sure food was labeled and dated when it was opened so the staff knew when the food would have gone bad. The Cook stated they would be thrown away. There was one opened plastic bag marked grated parmesan cheese that was wrapped in clear plastic wrap with no open or use by dates. There was one opened plastic bag marked mozzarella cheese that was wrapped in clear plastic wrap with no open or use by dates. The Cook was unable to state when they could have been used by and stated he would discard them. At 10:16 AM, the Director of Dietary (DD) joined the tour, and the Cook left the area. 2. In the freezer, there was one box marked pancakes with the inner clear plastic bag open with the pancakes visible and open to air. The surveyor inquired as to whether the pancakes should be visible and open to air and the DD stated "no," "because something could have been wrong with them," and that she would throw them away. There was one tied clear plastic bag containing round tan dough with brown chips, with no label or dates. The DD stated the bag contained chocolate chip cookies and acknowledged that the bag had no label. The DD stated the bag should have had a label marked	F 812	Control Committee and to the Quality Assurance Performance Improvement Committee quarterly for 6 months.	

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with the date that they were opened to make sure they were not old and out of date. There were two white undated cardboard packages marked cherry blintzes. The packages had tan stains and the edge of the packages were opened with the blintzes visible and open to air. The DD acknowledged the blintzes were not wrapped nor stored correctly and stated they should have been dated when they were taken out of the box. The DD removed them from the freezer.

3. In the can section in the dry storage room, there was one 6 lb dented can of crushed pineapple, one 106 ounce (oz) dented can of tropical fruit salad, and two 6 lb 10 oz dented cans of pumpkin. The DD removed the cans to the dented can section.

4. In the working supply overflow can section in the kitchen, there was one 6 lb 7 oz dented can of stewed tomatoes. The DD acknowledged the dented cans and removed them to the dented can section. The DD and stated it was important that the cans were not dented to prevent illness.

5. There was an uncovered mixer with the bowl visibly clean with white debris noted behind the bowl on the stand and brown debris on the handle. The DD acknowledged the debris, stated it should have been wiped and that it was important to keep the mixer clean to prevent cross contamination.

6. In the dairy prep area, there was one roll of clear plastic wrap that was uncovered and exposed and one roll of foil that was uncovered and exposed. The DD stated that the clear plastic wrap and the foil were used to cover pans and that they should not have been open and

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exposed because dust could have gotten on them.

7. In the spice area, there was one opened 16 oz jar of white pepper, one opened 18 oz jar of garlic powder, one opened 1 lb jar of celery seed, all with no open or use by dates and no expiration dates. The DD stated that the spices should have been dated when they were opened and threw the spices into the trash.

8. In the meat refrigerator, there was a large roasting pan partially covered with a sheet pan, with the meat visible and open to air and a label marked beef 1/30. The DD identified the meat as brisket and stated the meat should not have been visible.

9. In the freezer, there was a half pan covered with clear plastic wrap that was covered with ice with no labels or dates. The DD identified the contents as chicken backs bones and stated that it should have had a label with the date that the chicken was put in the freezer. The DD stated it was important that food was labeled and dated to ensure that it did not become potentially hazardous. The DD removed the pan from the freezer. Stuck to the underside of that half pan was a plastic bin that contained six packages of individually wrapped dark red meat, that the DD identified as beef shanks, that had ice and frozen red liquid in the bags. There were no labels and no dates. Stuck to the underside of the plastic bin was a sheet pan that contained a tied bag of frozen tan meat with no label and no dates. The DD identified the meat as chicken legs. Resting under the sheet pan was a cardboard box labeled boneless shank meat, dated 2021. Inside the box was a knotted clear plastic bag that contained

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F 812	Continued From page 45	F 812		

seven beef shanks with visible ice on the meat and in the bag, and a large piece of ice resting on the bag. The DD stated the meats were not stored correctly and that they should have been labeled with the received dates and dated when they were prepped and placed into the freezer. The DD further stated that it was important to store and label food correctly for safety, to decrease cross contamination and for the prevention of food borne illness.

10. In the dry storage area spice cabinet, there was one opened 8 oz jar of white pepper, one opened 12 oz jar of ground basil, one opened 1 lb jar of ground ginger and one opened 18 oz jar of garlic powder with no open or use by or expiration dates. The DD stated the spices should have been marked when they were opened and then disposed of them in the trash.

11. In the cook prep area, there was one roll of clear plastic wrap that was opened and uncovered. The DD stated the plastic wrap was used to cover food and that it should have been covered.

On 02/05/24 at 12:22 PM, in the presence of the DD, the surveyor observed the cook at the steam table plating food for the lunch meal. The cook was wearing a hair covering, surgical mask and gloves. The cook was observed to use the food scoop and tongs to plate the food, rested her hands on the counter, used the scoop and tongs again, then used her gloved hand to remove whole green beans from the steam table and placed them on a plate, rested her hands on the counter, touched the front of her surgical mask, then used the scoop to plate food again.

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F 812	Continued From page 46	F 812		

On 02/02/24 at 12:24 PM, the surveyor interviewed the cook who stated her role was to get the plate, place the food that was called out on to the plate, and then pass it to the dietary aide. The cook was made aware of the surveyor's observation when she used her hands to serve the green beans. The cook acknowledged that she should not have used her hands to serve the food and stated that she was in a hurry and trying to get the food out of the kitchen. The cook stated that it was important to use the utensils to serve the food to prevent cross contamination.

On 02/05/24 at 12:28 PM, the surveyor interviewed the DD who acknowledged that the cook plated the green beans with her hands. The DD stated that the cook should not have used her hands and that she should have used the tongs to serve the vegetables. The DD further stated that it was important to use the utensils to serve the food to prevent cross contamination.

A review of the facility policy, "Maintaining a Sanitary Tray Line," revised 3/2023, revealed Policy: This facility prioritizes tray assembly to ensure foods are handles safely and held at proper temperatures to prevent the spread of bacteria that may cause food borne illness. Compliance guidelines: 3. During tray assembly, staff shall: b. Use utensils such as tongs, serving spoons, etc. to handle food ...g. Change gloves after sneezing, coughing or touching face, hands or hair with gloved hand.

A review of the facility documentation, "Operations Policy and Procedure Manual Job Descriptions: Cook," revised 2/25/2008, revealed Duties and Responsibilities: Safety and Sanitation: 2. Ensure that safety regulations and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 47 precautions are followed at all times by all personnel. 3. Follow established Infection Control and Universal Precautions policies and procedures when performing daily tasks. NJAC 8:39-17.2(g)	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §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(i) Medical records. §483.70(i)(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(i)(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	F 842		3/15/24

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	315340	A. BUILDING _____ B. WING _____	C 02/08/2024

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F 842	Continued From page 48 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 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (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. §483.70(i)(5) The medical record must contain- (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. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that a resident's	F 842	1.Resident #140 no longer at the facility. Record of resident # 150 was reviewed. Nurse Identified was educated on proper	

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F 842	Continued From page 49 medical record contained an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress, specifically by failing to include pertinent information in the electronic medical record. The deficient practice was discovered for 1 of 1 resident (Resident # 150) reviewed for Medical Records. The deficient practice was evidenced by the following: A review of Resident #150's Electronic Medical Record (EMR) under Progress Notes revealed that he/she was discovered by staff NJ Exec. Order 26:4.b.1 . The note revealed that the Nurse Supervisor was notified and Resident #150 was NJ Exec. Order 26:4.b [redacted] The note concluded by revealing that the NJ Exec. Order 26:4.b.1 [redacted] were notified. A review of Resident #150's physician's orders in the EMR revealed that Resident #150 was a "Full Code," meaning life saving measures would have been implemented if the Resident's health declined. A review of the facility provided document titled, "Timeline" revealed a description of events by date and time leading up to Resident #150's NJ Exec. Order 2 [redacted] The timeline revealed that on NJ Exec. Order 26:4.b.1 [redacted] at 05:40 AM, NJ Exec. Order 26:4.b.1 [redacted] by the assigned nurse. The document concluded that NJ Exec. Order 26:4.b.1 at 05:50 AM. The document further revealed that Resident #150 was NJ Exec. Order 26:4.b.1 [redacted]	F 842	documentation in resident records. 2.All residents may be affected by nurses not thoroughly documenting in resident records. 3.DON or designee will complete documentation education for all nurses and will audit 5 charts per week for comprehensive documentation. In-service completed 2/13/2024. 4.DON or designee will report audit findings to Quality Assurance Performance Improvement Committee quarterly for 6 months.	

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F 842	Continued From page 50	F 842		

A review of the facility provided document titled, "Witness Statement" that was completed by the Registered Nurse present at the time of Resident #150's [NJ Exec. Order] confirmed that [NJ Exec. Order 26:4.b.1] around 05:45 AM on [NJ Exec. Order 26:4.b.1]. The document further revealed that once the physician was notified, [NJ Exec. Order 26:4.b.1] around 5:50 AM.

A review of the document titled [NJ Exec. Order 26:4.b.1] revealed that Resident #150's immediate [NJ Exec. Order 26:4.b.1] was a [NJ Exec. Order 26:4.b.1]). The document further revealed that the [NJ Exec. Order 26:4.b.1]

On 02/06/2024 at 04:02 PM, during an interview with the surveyor, the Director of Nursing (DON) confirmed [NJ Exec. Orde] was initiated at the time Resident #150 was discovered [NJ Exec. Order 26:4.b.1]. The DON further described that Resident #150 appeared to have been in [NJ Exec. Order 26:4.b.1]

On 02/07/2024 at 10:03 AM, during an interview with the surveyor, the Unit Manager/Registered Nurse replied, "Of course" when asked if [NJ Exec. Ord] had to be documented in a resident's progress note.

On 02/07/2024 at 10:36 AM, during an interview with the surveyor, Regional Nurse #1 replied, "Yes, absolutely" when asked if [NJ Exec. Orde] should have been included in the progress notes in the EMR. Regional Nurse #1 said at the time the nurse documenting could not access Resident #150's record due to Resident #150 being [NJ Exec. Order 26:4.b.1]

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F 842	Continued From page 51 A review of the facility provided policy titled, "Documentation of Medical Record" revealed, "Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation." N.J.A.C. § 8:39-35.2 (d) 6	F 842		
F 868 SS=B	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance	F 868		3/15/24

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F 868	Continued From page 52 activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the required members were present during the quarterly Quality Assessment and Assurance (QAA) committee meetings. This deficient practice occurred during 1 of the 4 meetings and was evidenced by the following: On 02/07/24 at 09:52 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding the Quality Assurance Performance Improvement (QAPI) process in the facility. According to the data provided by the facility, there was no physician, including the Medical Director (MD) or another designated physician, in attendance at the quarterly Quality Assurance (QA) meeting that was held on 05/11/23. On 02/07/24 10:30 AM, the surveyor reviewed the quarterly QA minutes in the presence of the LNHA. The LNHA stated that according to the attendance sign out sheet the MD did not sign that he was in attendance. The surveyor did observe that the minutes that were documented after the meeting were signed by the Medical	F 868	1.Quality Assurance Performance Improvement calendar meeting schedule was re-distributed to the Medical Director and to the staff committee members and a new record of attendance sheet created. 2.All residents may be affected by not having the Medical Director and/or required members in attendance at the Quality Assurance Performance Improvement meetings. 3.QAPI plan and policy In-service completed with all members required to attend meetings and in-serviced the importance of their participation and signing the record they were in attendance of the meeting. Administrator or designee will audit the sign in record quarterly to ensure its accuracy of attendance. 4.The Administrator and/or her designee will report audit findings quarterly to the Quality Assurance Performance Improvement Committee quarterly for 6	

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F 868	Continued From page 53 Director. The LNHA stated that these minutes were typed by the secretary after the meeting and was not sure when the MD signed the minutes. The LNHA stated that she could not recall if the MD was at the quarterly QA meeting because he did not sign the attendance sheet at the time the meeting was held. The facility policy titled, "Quality Assessment and Assurance Plan," dated 01/2024, indicated that QAPI was incorporated into the facility culture throughout all disciplines, service lines, to include board of directors and leadership. NJAC 8:39-33.1(b)	F 868	months.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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. §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: §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	F 880		3/15/24

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F 880	Continued From page 54	F 880		

conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(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
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

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F 880	Continued From page 55 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Complaint NJ # 165358 Based on observation, interviews, and review of facility documentation, it was determined that the facility failed to follow appropriate infection control practices and perform hand hygiene as indicated: a) during a meal tray pass observation for 1 of 4 units, (2 North unit), b) during medication administration for 1 of 3 residents observed (Resident #143), and c) during [redacted] for 1 of 3 residents observed (Resident #65). The deficient practice was evidenced as follows: 1. On 01/30/24 at 12:34 PM, the covered food cart arrived on The Shores hallway on Unit 2 North. At 12:51 PM, surveyor #1 observed a Certified Nursing Aide (CNA #1) who approached the food cart, removed a tray from the cart, entered Resident # 302's room and placed it on their bed side table (BST). CNA #1 then removed the lid from the foam cup, removed the lid from the orange soda bottle that was previously resting on the Resident's BST, poured the soda into the foam cup and replaced the lids on the soda and the foam cup. CNA #1 then removed the wrapping from the straw and placed the straw into the foam cup lid, removed the plastic plate cover and exited the room. CNA #1 returned to the food cart and placed the plastic plate cover on top of	F 880	1.CNA # 1 identified and was counseled and re-educated on proper hand hygiene protocols and hand hygiene when passing trays during meals. LPN # 2 was counseled and re-educated on performing proper hand hygiene during medication administration. LPN #3 and CNA#2 Counseled on hand hygiene between care tasks and glove donning and doffing procedures. Immediate full house education was provided to all staff on proper hand hygiene. Immediate in-servicing initiated for all staff on proper hand hygiene and infection control. 2.All residents may be affected by staff not following appropriate infection control practices and not following infection control policy and procedures. 3.Infection Preventionist and/or his or her designee will in-service all staff on infection control policy and procedures to include hand hygiene, donning and doffing, and infection control during meals and passing of trays and during care and treatments. Infection Preventionist will conduct weekly audits and provide ongoing education based on audit outcomes. In-service completed 2/14/2024.	

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F 880	Continued From page 56 the food cart, removed a meal tray from the cart and entered Resident #303's room and placed the meal tray on the BST. CNA #1 returned to the food cart, removed a tray, and placed it on top of the food cart. CNA#1 partially lifted the lid from the ice cream, removed the silverware from the plastic baggie with her hands and placed them on the tray, opened a can of cola and poured the contents into a foam cup, placed a lid on the cup, removed half the straw wrapper and placed the straw into the lid of the foam cup. CNA #1 then entered Resident #72's room and, while holding the meal tray in her left hand, used her right hand to remove trash from the BST and throw it into the trashcan. CNA #1 then placed the meal tray on the BST, moved the Resident's wheelchair closer to his/her bed, removed a blanket from the Resident, moved the Resident's legs over the side of the bed, NJ Exec. Order 26:4.b.1 [redacted], then provided [redacted] the Resident to the wheelchair and repositioned the Resident once in the wheelchair. CNA #1 then moved the wheelchair closer to the bed, moved the BST in front of the Resident, removed the lid from the soup, removed the lid from the ice cream, moved the foam cup closer to the Resident, removed the plastic lid from the plate and exited the room. CNA #1 placed the plastic lid on top of the food cart then moved the beverage cart, that was next to the food cart, into the snack room, opened the refrigerator and placed the containers of juice into the refrigerator. No hand hygiene was observed during the observation. On 01/30/24 at 12:58 PM, surveyor #1 interviewed CNA #1 who stated that when the food carts arrived on the unit that it was the CNA and nurse's responsibility to check the trays for	F 880	4.Infection Preventionist will review audits monthly and will report findings to infection Control Committee monthly for 6 months.	

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accuracy and to serve the trays to the residents. CNA #1 stated during meal tray pass that hand hygiene (HH), which she explained was washing with soap and water or using hand gel, should have been done before meal tray pass was started, when it was completed, and that sometimes she performed HH in between if she "touched their stuff like silverware or cups" and continued, "I was rushed today because the trays were late." Surveyor #1 informed CNA #1 of the meal tray pass observation and that no HH was observed. CNA #1 acknowledged that she did not perform HH between passing each resident's tray and that she should have performed HH after delivering Resident #302's tray. CNA #1 stated that it was important to have performed HH correctly to prevent cross contamination and shared germs.

On 01/30/24 at 01:15 PM, surveyor #1 interviewed the Licensed Practical Nurse (LPN #1) who stated that it was the CNA's responsibility to distribute meal trays on the unit and that HH should have been performed between each tray that was passed. Surveyor #1 informed LPN #1 of the CNA's meal tray pass observation. LPN #1 stated that CNA #1 did not perform HH correctly and that she should have cleaned her hands before and after touching each tray. LPN #1 further stated that it was important to perform HH correctly, so germs were not transferred from resident to resident.

On 01/30/24 at 01:26 PM, surveyor #1 interviewed the Licensed Practical Nurse Unit Manager (LPN/UM #1) who stated that staff were responsible for the distribution of meal trays on the unit and that she expected staff to perform HH before and after obtaining a meal tray and

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serving the next resident. Surveyor #1 informed the LPN/UM #1 of the CNA's meal tray pass observation. LPN/UM #1 acknowledged that CNA #1 did not perform HH correctly between each resident and stated that HH was important so germs were eliminated, and contamination was avoided.

On 02/01/24 at 10:42 AM, surveyor #1 interviewed the Assistant Director of Nursing (ADON) who stated that it was the CNA's responsibility to distribute meal trays on the unit and that HH should have been performed after the resident's trays were set down, if the CNA had to help the resident open food items, any contact with the resident, and when anything was touched. Surveyor #1 informed the ADON of the CNA's meal tray pass observation from 01/30/24. The ADON stated that CNA #1 did not perform HH correctly and that it was important for proper HH to prevent food borne disease and passing of germs.

On 02/01/24 at 11:26 AM, surveyor #1 interviewed the Infection Control Nurse (ICN) who stated that during meal tray pass, she expected HH to be performed when the trays were touched or when food was opened for a resident. Surveyor #1 informed the ICN of the CNA's meal tray pass observation from 01/30/24. ICN stated that CNA #1 did not perform HH correctly and that it was important for proper HH to prevent the spread of germs or infection.

On 02/01/24 at 11:41 AM, surveyor #1 interviewed the Director of Nursing (DON) who stated that the CNAs passed the meal trays to the residents, and she expected HH to have been performed every time they "touched anything" or

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 59	F 880		

they "go to get another tray on the cart." Surveyor #1 informed the DON of the CNA's meal tray pass observation from 01/30/24. The DON acknowledged that CNA #1 did no HH and that she expected staff to perform HH between each resident. The DON stated that it was important to perform HH correctly to prevent the passing of germs.

On 02/06/24 at 03:39 PM, the surveyors met with the administration team who were made aware of CNA #1's meal tray pass observation from 01/30/24.

A review of facility documentation revealed Meeting Sign-In Sheets for topics which included: Hand Hygiene ...signed by CNA #1 and dated 11/29/23, and 12/12/23.

A review of facility documentation, dated 12/02/23 and 01/10/24, revealed a Hand washing observation performed by CNA #1, and rated A=Performs skill independently and completely. Both forms were signed by an Observer.

A review of facility documentation revealed an Employee Education Packet, Hand Hygiene, dated 11/29/23, for CNA #1 with Competency Demonstrated box checked "YES" and Observer Initials marked.

2. On 02/01/2024 at 08:55 AM, during the Medication Administration task on 2 South unit, surveyor # 2 observed LPN # 2 administering medications to Resident # 19. Upon finishing the medication administration, surveyor # 2 observed LPN #2 exit the room and approach the medication cart. Surveyor # 2 then observed LPN #2 prepare medication for Resident #143. LPN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315340	A. BUILDING _____ B. WING _____	C 02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASHORE GARDENS LIVING CENTER	22 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 60	F 880		

#2 did not perform hand hygiene between finishing the medication administration with Resident # 19 and beginning the medication administration for Resident #143.

During an interview with surveyor # 2 at that time, LPN #2 was asked when hand washing was to be performed and LPN #2 stated, "between residents." When asked if she had washed her hands between Resident #19 and Resident # 143, LPN #2 responded, "No, I forgot."

On 02/01/24 at 11:37 AM, surveyor # 2 interviewed the Infection Preventionist (IP) who was asked when hand hygiene should have been done during medication administration. The IP stated, "hand hygiene should be done prior to starting, and after giving medication. They should use hand sanitizer or washing hands with soap and water. It is recommended to wash with soap and water every three patients."

3. On 02/02/24 at 11:00 AM, on 2 South Unit, surveyor #3 observed LPN#3 perform [NJ Exec. Order 26:4.b.1] for Resident #65, assisted by CNA#2. LPN/UM#2 was also present for the observation. LPN/UM #2 stated she was there to observe the [NJ Exec. Order 26:4.b.1], to complete competencies for LPN#3, and as moral support. Surveyor #3 observed CNA #2 enter the resident's room and don gloves. She then assisted LPN #3 in repositioning Resident #65's [NJ Exec. Order 26:4.b.1] hile the back of [NJ Exec. Order 26:4.b.1] was pulled down. CNA#2 then rolled the resident to their left side allowing LPN#3 to perform the [NJ Exec. Order 26:4.b.1]. At that time, CNA#2 held the resident in the side position by placing her gloved

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	315340	A. BUILDING _____ B. WING _____	C 02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASHORE GARDENS LIVING CENTER	22 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 61 hands-on the resident's NJ Exec. Order 26:4.b.1 [redacted] LPN#3 then proceeded to complete the NJ Exec. Order 26:4.b.1 on resident #65. With the same gloves, CNA#2 and LPN#3 redressed the resident, reapplied the NJ Exec. Order 26:4.b.1, and repositioned the resident. With the same gloves, CNA#2 then held the resident's hands, repositioned the resident's blankets, and adjusted the bed pillows. CNA#2 then removed her gloves and proceeded to the bathroom to wash her hands with soap and water for 40 seconds. On 02/02/24 at 11:25 AM, surveyor#3 interviewed CNA#2 and made her aware of the NJ Exec. Order 26:4.b.1 observations. CNA #2 stated that she was not aware of any breach in the infection prevention protocol and was not aware she did not change her gloves. CNA#2 stated she should have changed her gloves and that improper hand hygiene could have spread infection. On 02/02/24 at 11:35 AM, surveyor#3 interviewed LPN/UM#2 and discussed the NJ Exec. Order 26:4.b.1 observation. LPN/UM#2 stated that CNA#2 should have changed her gloves after she assisted with the NJ Exec. Order 26:4.b.1, before she proceeded to reposition the resident, and when she touched the resident's hands. A review of the facility policy, "Hand Hygiene," accessed June 2023, revealed, Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. "Hand hygiene" is a general term for cleaning your hands by handwashing with soap and water or	F 880		

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	315340	A. BUILDING _____ B. WING _____	C 02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASHORE GARDENS LIVING CENTER	22 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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F 880	Continued From page 62 use of an antiseptic hand rub ...Policy Explanation and Compliance Guidelines: 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. The handout "Hand Hygiene Table" revealed Condition: Between resident contacts, After handling contaminated objects, Before preparing or handling medications, Before and after handling clean or soiled dressings, linens etc., After handling items potentially contaminated with blood, body fluids, secretions, or excretions, When, during resident care, moving from a contaminated body site to a clean body site... A review of the undated facility policy, "Nursing Pertinent Policies," revealed, Assisting the Resident with In-Room Meals, Preparation: 11. Employees must wash their hands before serving food to residents ...if there is contact with soiled dishes, clothing or the resident's personal effects, employee must wash his/her hands before serving food to the next resident. NJAC 8:39-19.4 (m)(n)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030102	A. BUILDING: _____ B. WING _____	C 02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASHORE GARDENS LIVING CENTER	22 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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S 000	Initial Comments Complaint # NJ: 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 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # NJ:168566, 165358 and 170029 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratio, as mandated by the State of New Jersey. This deficient practice was identified for 2 of 2 weeks of complaint staffing reviewed and 2 of 2 weeks of staffing prior to the recertification survey dated 02/08/24. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health	S 560	1.Nursing schedules completed a month in advance. Overtime is offered is offered to our staff to help meet ratios. Agencies are contacted to fill shifts we are unable to fill with our own staff. We will use texting communication system to reach out to our staff to fill shifts and if any call outs. Nursing supervisors have updated staff contact list and agency numbers in case call outs. We continue to offer sign on bonuses to attract staff and rates are reviewed and competitive. 2.All residents may be affected by not meeting staffing ratios.	3/15/24

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

Electronically Signed | 03/01/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SEASHORE GARDENS LIVING CENTER	22 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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S 560	Continued From page 1 (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 Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) 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. A review of the "Nurse Staffing Report" for the following weeks provided by the facility revealed the following: 1. For the week of Complaint staffing from 10/22/2023 to 10/28/2023, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -10/22/23 had 12 CNAs for 141 residents on the day shift, required at least 18 CNAs. -10/28/23 had 15 CNAs for 136 residents on the day shift, required at least 17 CNAs. 2. For the week of Complaint staffing from	S 560	3.Facility strives to meet the ratios by the following: Sign on bonuses offered, employee referral bonus program, Human resources to prioritize CNAs and expedite applications. We continue to advertise on platforms and visit schools. We will be scheduling another job fair and we are participating with one local vocational school to be a training site. Scheduler will document all of her efforts to fill the shifts. Human Resources will keep a tracker log of new CNA hires and work on recruitment. 4.Scheduler with review the schedules daily and will report any issues with meeting the ratios to the Director of Nurses and/or the Administrator daily. Human resources Coordinator will report recruitment statistics quarterly to Quality Assurance performance Improvement Committee quarterly for 6 months.	

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S 560	Continued From page 2 12/31/2023 to 01/06/2024, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -12/31/23 had 15 CNAs for 142 residents on the day shift, required at least 18 CNAs. -01/06/24 had 15 CNAs for 145 residents on the day shift, required at least 18 CNAs. 3. For the 2 weeks of staffing prior to survey from 01/14/2024 to 01/27/2024, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows: -01/14/24 had 16 CNAs for 141 residents on the day shift, required at least 18 CNAs. -01/20/24 had 17 CNAs for 142 residents on the day shift, required at least 18 CNAs. -01/21/24 had 16 CNAs for 142 residents on the day shift, required at least 18 CNAs. -01/27/24 had 16 CNAs for 146 residents on the day shift, required at least 18 CNAs. On 02/05/24 at 11:07 AM, the surveyor interviewed the Staffing Coordinator (SC) who stated that she was responsible for staffing for the building. When asked how the staffing was determined for each unit the SC stated that she staffed the units based on the state regulations which was one (1) CNA to eight (8) residents on day shift; 1 CNA to 10 residents on evening shift; and 1 CNA to 14 residents on night shift. The SC stated that staffing was reassessed by her every shift except between 12am to 8am which was done by the night supervisor. She further stated that if the facility census changed, she took that into consideration. She explained that if the census raised, she would put more aides on and	S 560		

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S 560	Continued From page 3	S 560		

if it was lower then she would take the aides off. The SC emphasized "but I stayed within the state requirements." The SC stated that they had a program which put a universal call or text blast to the CNAs and nurses. She further stated that she also personally called staff.

On 02/05/24 at 11:20 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) in the presence of the survey team. The LNHA stated the New Jersey state staffing requirement was 1 CNA for 8 residents on the 7:00 AM - 3:00 PM shift, 1 CNA for 10 residents on the 3:00 PM - 11:00 PM shift, and 1 CNA for 14 residents on the 11:00 PM -7:00 AM shift. When asked how the staffing levels were determined, both the LHNA and the DON stated that they calculated staff based on the census and if they felt that they had a higher acuity, then they would make a determination to add additional staff. The LNHA further stated that they asked the staffing coordinator if there were any call outs and then the SC would call the agencies as well, but that they preferred to use their own staff first before agency "because they know our residents better." The DON added the supervisors also contacted staff to ensure the shifts were covered.

Review of the facility policy, "Nursing Pertinent Policies- Nursing Services Staffing," dated February 2023, included, "1.) The facility will supply services by sufficient number of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans. a.) Except when waived, licensed nurse; and b) other personnel, including but not limited to nurse aides. 3). The facility is required to provide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 4 license nursing staff 24 hours a day, 7 days a week. CNAs: Day:1:8; Evenings: 1:10; and Night 1:14. 5) Providing care includes , but not limited to assessing , evaluating , planning and implementing resident care plans and responding to resident needs."	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315340	A. Building B. Wing	3/15/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASHORE GARDENS LIVING CENTER	22 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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 F0641 Reg. # 483.20(g) LSC	Correction Completed 03/15/2024	ID Prefix F0686 Reg. # 483.25(b)(1)(i)(ii) LSC	Correction Completed 03/15/2024	ID Prefix F0800 Reg. # 483.60 LSC	Correction Completed 03/15/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
2/8/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315340 Y1	A. Building B. Wing Y2	3/15/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASHORE GARDENS LIVING CENTER	22 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0641	Correction	ID Prefix F0656	Correction	ID Prefix F0679	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.24(c)(1)	Completed
LSC	03/15/2024	LSC	03/15/2024	LSC	03/15/2024
ID Prefix F0686	Correction	ID Prefix F0689	Correction	ID Prefix F0759	Correction
Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.45(f)(1)	Completed
LSC	03/15/2024	LSC	03/15/2024	LSC	03/15/2024
ID Prefix F0761	Correction	ID Prefix F0800	Correction	ID Prefix F0812	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	03/15/2024	LSC	03/15/2024	LSC	03/15/2024
ID Prefix F0842	Correction	ID Prefix F0868	Correction	ID Prefix F0880	Correction
Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. # 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	03/15/2024	LSC	03/15/2024	LSC	03/15/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/8/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
030102 Y1	A. Building B. Wing Y2	3/15/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASHORE GARDENS LIVING CENTER	22 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/15/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
2/8/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315340	A. BUILDING **02** B. WING _____	**02/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASHORE GARDENS LIVING CENTER	**22 WEST JIMMIE LEEDS ROAD** **GALLOWAY TOWNSHIP, NJ 08205**

(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 An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, (NJDOH) on 02/08/23. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 02/08/24 was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Seashore Gardens is a two-story building that was built in 2011 and is composed of Type II protected construction. The facility is divided into six - smoke zones. The generator does approximately 100 % of the building per the Maintenance Director. The current occupied beds are 147 of 151.	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type	K 161		3/15/24

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

Electronically Signed | 03/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315340	A. BUILDING **02** B. WING _____	**02/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 161	Continued From page 1 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure fireproofing was applied to the steel beams in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.1.6.1. This deficient practice had the potential to affect all 147 residents.	K 161	1.Fireproofing product ordered and Fireproofing completed on steel Column identified on 2/23/24. 2.All residents, staff, and visitors may be affected by not having fireproofed steel Columns.	

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	315340	A. BUILDING **02** B. WING _____	**02/08/2024**

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K 161	Continued From page 2 Findings include: An observation on 02/08/24 at 12:43 PM revealed the fireproofing was removed from one steel column approximately 24" x 12" in the electrical room when a water break occurred. During an interview at the time of observation, the Maintenance Director confirmed the fireproofing was missing from the steel column in the electrical room. NJAC 8:39-31.1(c), 31.2(e)	K 161	3.Maintenance Manager or his designee will review all areas where fireproofing required. No other areas identified. Maintenance Manager will add fireproofing to maintenance log. 4.Maintenance Manager will check areas weekly and will report any area needing fire fireproofing immediately to administrator. Maintenance Manager or designee will report findings monthly to safety and findings quarterly to quality assurance performance improvement committee for six months.	
K 347 SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke detection was installed in rooms open to the corridor in accordance with NFPA 101 Life Safety Code (2012 edition) section 19.3.6.1. This deficient practice had the potential to affect all 147 residents who resided at the facility. Findings include: Observations on 02/08/24 at 12:21 PM revealed that no smoke detectors were located in the	K 347	1.Two smoke detectors installed in the dining rooms identified on 2/14/24 by contractor and connected to our fire monitoring system. 2.All residents, staff, and visitors may be affected by not having smoke detectors in dining areas identified. 3.Maintenance Manager or his designee will add these detectors on maintenance log to ensure in place. Alarms are monitored by ADT 24 hours 7 days per week for any faults.	3/15/24

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	315340	A. BUILDING **02** B. WING _____	**02/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 347	Continued From page 3 dining room on the first floor or in the dining room on the second-floor next to the nurses' stations that were open to the corridor. During an interview at the time of the observation, the Maintenance Director confirmed the smoke detectors were not installed in the resident dining rooms. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 347	4.Maintenance Manager or designee will review all Maintenance/Inspection logs monthly and will report any maintenance issues immediately to administrator. Maintenance Manager or designee will report findings monthly to safety committee and findings quarterly to quality assurance performance improvement committee for six months.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315340	A. Building 02 - SEASHORE GARDENS B. Wing	3/28/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASHORE GARDENS LIVING CENTER	22 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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 Reg. # NFPA 101 LSC K0161	Correction Completed 03/15/2024	ID Prefix Reg. # NFPA 101 LSC K0347	Correction Completed 03/15/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
2/8/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO