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 10/04/2021

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 000	INITIAL COMMENTS STANDARD SURVEY: CENSUS: 99 SAMPLE: 22 + 2 closed records The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey. Complaint # NJ 00146602 In addition, a complaint investigation was completed. The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care facilities, based on this complaint.	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: Based on observation, interview, review of the medical record and other facility documentation, it was determined that the facility failed to ensure that an accurate Minimum Data Set (MDS), an assessment tool, was completed. This deficient practice was identified for 2 of 22 residents reviewed (Residents [redacted] and [redacted]) and was evidenced by the following: 1.Resident [redacted] was a resident in the facility with diagnoses which included [redacted] and	F 641	1. MDS (Minimum Data Set) Coordinator corrected assessment for resident [redacted] for pain management and corrected coding on Minimum Data set (MDS) assessment for resident [redacted] for [redacted]. 2. All residents have the potential to be affected by inaccurate coding on assessment. MDS (Minimum Data Set) Coordinator reviewed all residents with a care plan for [redacted] and [redacted]. 17 resident's assessments reviewed for [redacted] and one additional resident	11/18/21

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

Electronically Signed | 10/22/2021

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 10/04/2021

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 641	Continued From page 1 [redacted]. During an interview on 9/20/21 at 01:05 PM, Resident [redacted] stated he/she said receives [redacted] medication twice a day for[redacted] said his/her[redacted] is getting better every day. A review of the [redacted] MDS for Resident [redacted], reflected that Resident [redacted] had a Brief Interview for Mental Status score of [redacted] when interviewed by staff. On the [redacted] section of the MDS for the question should the pain assessment interview be conducted; it indicates a 0 no (resident is rarely/never understood). During an interview with the surveyor on 9/23/21 at 11:35 AM, the Registered Nurse MDS Coordinator acknowledged that the[redacted] section for Resident [redacted] MDS is inaccurate. She stated that the [redacted] assessment interview question should have been coded as a 1 (yes) and the[redacted] assessment interview should have been conducted for Resident [redacted]. 2. Resident [redacted] was a in the facility with diagnoses which included [redacted] on [redacted]. A review of a facility weight chart for 2020 and 2021 for Resident [redacted] revealed weights as follows: December 2020 [redacted], June 2021 [redacted] July 2021 [redacted], August [redacted], September [redacted]. On Resident[redacted] March MDS [redacted] weight is documented as [redacted] A review of the [redacted] MDS for Resident [redacted] under section K, Swallowing/Nutritional Status, revealed a weight of [redacted] pounds with a weight loss of 5% or more in last month or 10% or more	F 641	assessment was updated. 54 resident's assessments reviewed for [redacted] and all had accurate coding on latest assessment. 3. MDS (Minimum Data Set) coordinator will review MDS with unit managers along with the review of medical record to ensure coding accuracy prior to submission of MDS. Staff educated to use dry weight on assessments for residents on dialysis and dry weight category added to the log for one resident identified. 4.DON (Director of Nurses) or designee will audit 5 MDS (Minimum Data Set) assessments per month for 6 months prior to submission. Director of Nurses and or designee will report findings quarterly to Quality Assurance Performance Improvement Committee.	

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 10/04/2021

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 641	Continued From page 2 in [redacted] months. (This was not a significant [redacted]). Resident [redacted] MDS reflects a weight of [redacted] with a [redacted] of 5% or more in last month or 10% or more in 6 months. According to Resident [redacted] chart [redacted] weight is [redacted] with no significant [redacted] During an interview with the surveyor on 9/23/21 at 11:35 AM, the Registered Nurse MDS Coordinator acknowledged that Resident [redacted] MDS should not be coded as a [redacted] of 5% or more in last month or 10% or more in [redacted] months. She also acknowledged that Resident [redacted]'s [redacted] Q MDS weight was coded incorrectly and should be coded as [redacted] pounds with no significant [redacted]. During an interview with the surveyor on 9/23/2021 at 12:58 PM, the Registered Dietician stated that Resident [redacted] MDS should not have been coded as [redacted] of 5% or more in last month or 10% or more in [redacted] months.	F 641		
F 688 SS=D	NJAC 8:39-11.1 Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		11/18/21

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 10/04/2021

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 688	Continued From page 3 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other documentation, it was determined that the facility failed to ensure a [redacted] was applied and removed daily according to the physician's order, for 1 of 2 residents reviewed for limited range of motion, (Resident [redacted]). This deficient practice was evidenced by the following: On 9/20/21 at 11:57 AM, the surveyor observed resident [redacted] in the residents' room, sitting in a wheelchair, neatly dressed and groomed. The residents' [redacted] was lying [redacted] against his/her [redacted]. Resident [redacted], using his/her [redacted], positioned his/her [redacted] across his/her lap. The surveyor observed that the resident's [redacted] was [redacted] There was no [redacted] in place. The resident stated that he/she is mostly independent but needs assistance transferring and getting dressed. The resident added that he/she does not use a [redacted] for [redacted] and said, [redacted] A review of the resident's medical records identified that the resident was admitted to the facility with diagnoses which included but not limited to; [redacted]	F 688	1.Resident [redacted] was reassessed by therapy department and a new type of [redacted] was given to resident. An ordered for [redacted] received and is on the treatment record. 2.Residents having a treatment order for adaptive equipment may be affected. One additional resident was found to have an order for a [redacted]. Orders for both are in place. 3.Education completed to occupational therapist to ensure orders are placed for treatment and will use a flow sheet to monitor. Education/training program was given by records consultant to nurses which included documenting in treatment record regarding any devices such as [redacted]. Nurses are to document on treatment record use or denial and reason of adaptive equipment not in use by resident. Any denials will be reported to social services for a team intervention with resident and care plan adjustment if necessary. The Unit Manager will observe resident and check treatment records weekly to ensure residents are receiving the [redacted] and proper documentation is completed. 4.Director of Nursing or designee will audit charts monthly for residents having orders for adaptive equipment and report findings to Resident Safety Committee and Quality	

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 10/04/2021

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 688	Continued From page 4 [redacted].	F 688	Assurance Improvement Committee quarterly.	

A review of Resident [redacted] Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], revealed a Brief Interview for Mental Status (BIMS) score of [redacted], indicating that the resident is cognitively intact. Under section [redacted] Special Treatments, Procedures, and Programs, restorative nursing programs included a [redacted].

A review of the [redacted] 2021 Physician's Order Summary Report revealed a physician order with an original start date of [redacted] for a [redacted]; [redacted] Day shifts and evening shift.

A review of the Treatment Administration Record (TAR) dated [redacted] of 2021, included documentation that the [redacted] had been applied and removed as ordered.

During an interview with the surveyor on 9/21/21 at 09:05 AM, Licensed Practical Nurse/Unit Manager (LPN/UM #2) was asked if the Resident [redacted] had a [redacted]. At that time, the surveyor and LPN/UM #2 reviewed the TAR that indicated that the [redacted] was in the treatment plan and documented as applied and removed. The UM stated that if the resident was not wearing the [redacted], it must be in in her room. The surveyor and LPN/UM #2 went to the resident's room and LPN/UM #2 was unable to locate the [redacted]. LPN/UM #2 asked Resident [redacted] where the [redacted] was and the resident replied, [redacted] LPN/UM

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 10/04/2021

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 688	Continued From page 5	F 688		

#2 stated that she would follow up with Occupational Therapy and said maybe it was discontinued, and we didn't take it off the TAR.

During an interview with the surveyor on 9/22/21 at 10:13 AM, the Therapy Program Manager (TPM) stated that the process for notification of changes in services are documented in the therapy network computer system. The TPM said the therapist will notify the nurses of any changes such as resident refusal of treatment. She went on to say the therapist will complete a "Nursing/Therapy Communication for Adaptive Equipment and Positioning" form to give to nursing. The TPM also said that the therapist is responsible for documenting a formal order in the electronic record that is accessible to nursing and physicians. The TPM was unable to provide copies of the Nursing/Therapy Communication for Adaptive Equipment and Positioning form for Resident [redacted]

During a follow up interview with the surveyor on 9/23/21 at 11:03 AM, the TPM stated that the therapist documented in therapy notes to discontinue the [redacted] and to use a [redacted] but it was not appropriately communicated to nursing or the physician. The TPM acknowledged that there was no documentation in the EMR that the order was discontinued by therapy, nor was there a Nursing/Therapy Communication for Adaptive Equipment and Positioning form to alert nursing.

During an interview with the surveyor on 9/28/21 at 10:37 AM, the Certified Nursing Assistant (CNA #2) caring for resident [redacted], stated that she has not seen the resident wearing a [redacted] or appliance while under her care for the past week.

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 10/04/2021

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 688	Continued From page 6 During an interview with the surveyor on 9/28/21 at 10:40 AM, LPN #2, caring for Resident [redacted], stated that she has been the resident's primary day shift nurse for the past six months. LPN #2 added that she had never seen the resident wearing a [redacted] or any other [redacted] device including a [redacted] during that six-month period. A review of an undated facility policy titled "Coordination of Specialized Rehabilitative Services," revealed under the Policy Interpretation and Implementation section, number 3. Once a resident has met his/her care plan goals, a licensed professional can either discontinue treatment and will give discharge recommendations to the nursing supervisor and/or designee who will implement to assure that the resident maintains his/her functional and physical status. NJAC 8:39-11.2 (b)	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 690		11/18/21

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 10/04/2021

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 690	Continued From page 7 catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to a) maintain a [redacted] in manner to promote dignity, b) failed to ensure the [redacted] did not come into contact of the floor, c) change a resident [redacted] daily as per facility policy for 2 of 2 Residents reviewed for [redacted] (Resident [redacted] and Resident # [redacted] . This deficient practice was evidenced by the following: 1. During the initial tour of the [redacted] unit on 9/17/21 at 11:41 AM, Resident [redacted] was observed lying in bed. The [redacted] was attached to the bed and visible from the hallway and not in a [redacted] On 09/21/21 at 11:31 AM, Resident [redacted] was observed in his/her room sitting in a wheelchair.	F 690	1.Resident [redacted] identified and the entire [redacted] were changed and the [redacted] was put in place. Staff on unit for this resident educated by Unit Manager regarding [redacted] are one time use, [redacted] must be in place and to check to make sure [redacted] not on floor. Resident [redacted] Single use [redacted] was discarded. Nursing staff instructed on using single use [redacted] supplies and discard after each use. 2.Any resident with a [redacted] may be affected by unnecessary use. Residents with [redacted] within the facility evaluated every day for medical necessity from physical diagnosis, healing, measures or requested palliative care. [redacted] is to be removed	

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 10/04/2021

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 690	Continued From page 8 The [redacted] was in a [redacted] attached under the [redacted] of the wheelchair in contact with the floor. On 9/22/21 at 11:58 AM, Resident [redacted] was observed in his/her room sitting in the wheelchair. The [redacted] was in a [redacted] attached under the [redacted] of the wheelchair in contact with the floor. On 9/27/21 at 09:18 AM, Resident [redacted] was observed lying in bed watching TV. The [redacted] was attached to the bed, with the [redacted] above the [redacted] itself. The [redacted] was in contact with the floor and visible from the hallway. According to the Record of Admission, Resident [redacted] was admitted with diagnosis including but not limited to: [redacted]. A review of the Minimum Data Set (MDS) an assessment tool, dated [redacted], revealed a Brief Interview for Mental Status (BIMS) score of [redacted] indicating the resident is [redacted] The MDS further revealed the Resident has [redacted] r. A review of Resident [redacted] s care plan revealed under Problem/Strengths section with original date of [redacted] At risk for complications related to use of [redacted]. Under the Goal revealed will remain free of [redacted] Under the interventions section indicated "Keep [redacted] covered to promote dignity." During an interview with the surveyor on 9/22/21 at 11:51 AM, Certified Nursing Assistant (CNA# 1) said we put the [redacted] when they come out and hang under the wheelchair. CNA #1 went on to say No, the [redacted] shouldn't be	F 690	promptly upon assessment when no longer needed. [redacted] Program updated to include single use [redacted] to be discarded after each use, [redacted] to be covered at all times and if [redacted] touches floor it is considered contaminated and the [redacted] system replaced. Nurses and CNAs were in-service on the updated [redacted] procedures and reinforced the infection control aspects of the [redacted] system and priority of removal of unnecessary [redacted]. Emphasis was on single use and discarding, and privacy for a resident with a [redacted]. Nursing staff to report to social services any resident that desires not to use privacy measures in communal areas for counseling when appropriate. Nursing managers to observe daily proper placement and single use and report any irregularities at daily staff meeting to be addressed by the Director Nursing or his/her designee. 4.Infection Preventionist will conduct a weekly audit of residents with [redacted] to ensure proper placement and no known infections. Infection Preventionist will instruct immediately nurses on any deviation and report to Director of Nursing. Infection Preventionist will collect data and report findings to the Infection Control Committee quarterly and Quality Assurance Performance Improvement Committee quarterly for next six months.	

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 10/04/2021

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 690	Continued From page 9	F 690		

touching the floor even in [redacted]. If a resident uses [redacted] I put it on during AM care. She also said when the [redacted] is dirty I tell the nurse and get a new one. We don't change the [redacted] every day.

On 9/22/21 at 11:58 AM the surveyor accompanied by the Licensed Practical Nurse/Unit Manager (LPN/UM #1), went to Resident [redacted] room. The LPN/UM #1 confirmed the [redacted] was in contact with the floor. The Unit Manager said No it ([redacted]) is supposed to be off the floor.

During an interview with the surveyor on 9/27/21 at 12:37 PM, the Director of Nursing said the expectation is the [redacted] should be covered in [redacted] when in the bed and wheelchair and not to be on the floor.

2. During the initial tour of the [redacted] unit on 9/17/21 at 10:16 AM, the surveyor observed a [redacted] that was attached to Resident [redacted] bed frame. The [redacted] contained [redacted] and was not covered to maintain privacy.

During an interview with the surveyor on 9/21/21 at 9:33 AM, Resident [redacted] stated that he/she wears a [redacted]) when he/she is in a wheelchair. At that time, the surveyor observed that the [redacted] attached to the bed was not covered to maintain privacy.

A review of the MDS dated for [redacted] revealed Resident [redacted] had a BIMS score of [redacted] indicating the Resident is [redacted]. The MDS also revealed that Resident [redacted] had an [redacted].

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 10/04/2021

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 690	Continued From page 10	F 690		

A review of the Care Plan (plan that provides direction on an individual's care) revealed Resident [redacted] had an [redacted] due to [redacted].

During an interview with the surveyor on 9/21/21 at 10:01 AM, Certified Nursing Assistant (CNA #2) said that Resident [redacted] is [redacted] and replaced with a [redacted] when he/she gets up. She also said Resident [redacted] is rinsed after use and stored in a plastic bag that's inside the bathroom. She said that Resident [redacted] gets a new [redacted] weekly. CNA #2 further stated that Resident [redacted] does not need a [redacted] for the [redacted] because he/she uses a [redacted] that is under his/her clothing.

During an interview with the surveyor on 9/21/21 at 12:54 PM, Licensed Practical Nurse (LPN #1) said Resident [redacted] gets a [redacted] about every week.

A review of the manufacture package instructions for the "[redacted] Resident [redacted] uses) indicated that the [redacted] is single use.

A review of a facility policy titled, "Preventing [redacted] " with review dates of 1/2019 and 11/2020, under section 3.3 revealed, "If there are breaks in aseptic technique, [redacted] should be replaced. The [redacted] should be disinfected with [redacted] before connection to the [redacted] system. If the [redacted] becomes contaminated, the [redacted] should also be replaced. [redacted] may be changed one time using

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 10/04/2021

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 690	Continued From page 11 aseptic technique." NJAC 8:39-19.4 (a) 8:39-27.1(a)	F 690		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs	F 758		11/18/21

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 10/04/2021

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 758	Continued From page 12 are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to A.) provide a duration of use for an order of [redacted] (a [redacted] medication) as needed and B.) failed to follow the duration indicated on the controlled drug administration record by administering [redacted] past the duration of the order for 2 of 5 residents reviewed for unnecessary medications, (Resident [redacted], Resident [redacted]). The deficient practice was evidenced by the following: 1. According to a Minimum Data Set (an assessment tool), dated [redacted], Resident [redacted] had diagnoses including but not limited to; [redacted]). A review of Resident [redacted] physician's orders revealed an order dated [redacted], for [redacted]	F 758	1.Resident [redacted] evaluated by the physician. The PRN [redacted] was discontinued, and physician updated resident chart and included rationale for the prior use. Resident [redacted] was evaluated by the physician and the [redacted] was discontinued and resident chart updated and included the rational for the prior use. 2.All residents having an order for PRN [redacted] medications may be affected. 13 additional residents were identified as having a PRN [redacted] Medication orders exceeding the 14 day PRN duration and those orders discontinued. 3.Education in-service was given to the physicians and nurses regarding the 14-day limitation on all [redacted] PRN orders and documentation of clinical rational for the extension and providing a specific duration of use. Nurses educated on procedure to contact physician to discontinue or to see resident and document rationale for continuing the	

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 10/04/2021

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 758	Continued From page 13 milligram (mg) [redacted] as needed every 4 hours. The directions for use indicated to apply [redacted] mg by [redacted] every four hours as needed, if ora[redacted] is not tolerated. A further review of the physician's orders revealed that the order for oral [redacted] mg tablet was discontinued on [redacted]. A review of the Controlled Drug Administration Record (Count-down log of the receipt and administration of controlled drugs) with a received date of [redacted], labeled for [redacted] (generic name [redacted] mg/ml (milliliter) [redacted]. The label instructions for use indicated, "Apply one [redacted] as needed for 14 days (only if ora[redacted] not tolerated)." A review of the Controlled Drug Administration Record showed administration of the [redacted] from [redacted] through [redacted]. During an interview with the surveyor on 9/23/21 at 12:41 PM, Licensed Practical Nurse (LPN #2) said Resident [redacted] did not have an order for oral [redacted] During an interview with the surveyor on 9/28/21 at 8:38 AM, Licensed Practical Nurse/Unit Manager (LPN/UM #2) confirmed an order for [redacted] mg that began in [redacted]. LPN/UM #2 said she was not sure how the order for [redacted] did not come out of the system after 14 days. During an interview with the surveyor On 9/28/21 at 10:00 AM, when asked if a new order for [redacted] was needed after 14 days, the Assistant Administrator said the physician should have written a new script.	F 758	order. 4.Pharmacy Consultant will audit PRN orders for [redacted] medications monthly and report finding to the DON and to the Pharmacy Committee quarterly for six months.	

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 10/04/2021

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 758	Continued From page 14	F 758		

A review of the "Consultant Pharmacy Evaluation" form for Resident [redacted] did not include documentation regarding the as needed [redacted] from [redacted] through [redacted].
2. According to Resident #16's medical record (MR), Resident [redacted] had the following diagnoses: [redacted]

A review of the physician's orders revealed Resident [redacted] had the following order, dated [redacted] mg tablet 1 tablet ([redacted] mg) by oral route every 4 hours for 30 days as needed for [redacted].

According to the MDS dated [redacted], Resident [redacted] had a Brief Interview for Status score of [redacted], indicating severe cognitive impairment. Section [redacted] of the MDS identified the following active [redacted] disorders: [redacted]. Section [redacted] of the MDS revealed that Resident [redacted] received daily [redacted] medication.

A review of the monthly Consultant Pharmacist Evaluation (CP) form for Resident [redacted] revealed that on [redacted], the CP made the following comment: "[redacted] - past stop (x 30 days)"

A review of the Medication Administration Record Form (MAR) for [redacted], and [redacted], revealed that Resident [redacted] had an order for [redacted] mg tablet give 1 tablet [redacted] mg) by oral route every [redacted] hours for 30 days as needed for [redacted], dated [redacted]. A review of the [redacted] MAR for Resident [redacted] revealed an order for [redacted] mg

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 10/04/2021

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 758	Continued From page 15	F 758		

tablet give 1 tablet [redacted] mg) by oral route every [redacted] hours for 30 days as needed for [redacted], start date [redacted] and a discontinuation date of [redacted].

During an interview with the surveyor on 9/27/2021 at 10:22 AM, LPN/UM#3 stated, I believe the physician renewed the prescription. We get the monthly recommendations from pharmacy and we read what is on there and we will contact the physician to see if they agree or disagree with the recommendations. [redacted] does a lot of our recommendations but since he/she is on [redacted] the physician and [redacted] collaborate for [redacted] care needs.

A review of the Consultant Pharmacist's Monthly Report, the CP had the following suggestion dated [redacted] for Resident [redacted] "The medication administration record should clearly indicate the last day for prn (as necessary) [redacted] therapy (was ordered for 30 days on [redacted]). Please discontinue prn[redacted]." A review of the Action Taken response area of the sheet revealed the following: "Noted. Med continued per MD."

During an interview with the surveyor on 9/28/2021 at 10:03 AM, the Director of Nursing (DON) presented the surveyor with a physician progress note, dated [redacted] for the continued use of oral [redacted] The surveyor referenced that the original order for the oral [redacted] was dated [redacted]. The DON responded, "That would have expired after 30 days and we would have had to get a new order and the physician would have to document a rationale for continuation of the drug." The DON further stated, "The [redacted] CP recommendation was addressed, I'm told." The

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 10/04/2021

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 758	Continued From page 16	F 758		

surveyor asked the DON what the time frame would be for the facility to respond to the CP monthly recommendations, per facility policy. The DON responded, "I'm not sure of the time frame we have to respond but I tell our nurses to try and get it done within a week, preferably sooner. The pharmacist emails them to us and then we distribute it to our nursing units. I'm not sure if we have a policy for that at this time." The surveyor then asked the DON how the 30-day [redacted] order with a start date of [redacted] could continue for approximately 3 months without a documented physician rationale and a new prescription. The DON responded, "In order for the order to continue we would need to have a new prescription every 30 days with a documented rationale by the physician."

A review of the facility Integrated Progress Notes for Resident [redacted], with a date range of [redacted] up to and including [redacted] did not include documentation of a rationale for continued use of [redacted]

A review of the facility policy title, [redacted] Medication Policy and Procedure" with a review date of 5/2021, under the section titled, "Responsible Party - Actions Required: Primary Care Physician, PA or APN" number 2. revealed, "Document's rationale and diagnosis for use and identifies target symptoms." Number 8. under the same section revealed, "Orders for PRN [redacted] medications will be time limited (i.e., times 2 weeks) and only for specific clearly documented circumstances."

A review of the same policy under the section titled, "Pharmacist and/or consulting pharmacist", number 7. revealed, "Monitors [redacted] drug use in the facility to ensure that medications are

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 10/04/2021

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 758	Continued From page 17 not used in excessive doses or for excessive duration." Number 9. under the same section revealed, "Notifies the physician and the nursing unit if whenever a [redacted] medication is past due for review." The surveyor reviewed the facility policy titled Monthly Consultant Reports, reviewed date: 4/13. The following was revealed under the heading Policy Interpretation and Implementation: 2. "It is the responsibility of the Director of Nursing Services to implement the consultant's recommendations."	F 758		
F 812 SS=F	N.J.A.C. 8:39-29.3(a)(4) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		11/18/21

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 10/04/2021

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 812	Continued From page 18 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 9/17/2021 from 9:58 to 10:55 AM, the surveyors, accompanied by the Food Service Director (FSD), observed the following in the kitchen: 1. The FSD was observed to perform testing of the wash water temperature and the sanitizer level of the three-compartment sink. Upon completion of the temperature and sanitizer level the surveyor requested to see a copy of the temperature and chemical sanitization logs for the three-compartment sink. The FSD stated, "I don't have a temperature log or sanitizer level log for the three-compartment sink. I've never had a log for that in 18 years." The FSD further stated, "You're right, I should have one for monitoring purposes. We test for sanitizer and the maintenance department tests the water temperatures. We will have to start a log." 2. During the observation of the high temperature dishmachine the surveyor observed the assigned Kitchen Utility (KU) staff member utilize a 1-Temp-Thermolabel (a test strip for verifying cage washer sanitation, for cart washers and washer disinfectors to assess for appropriate water temperatures). The FSD explained that the thermo label is then attached to the Dish Machine Temps log for monitoring. The log is completed three times a day for the breakfast, lunch, and	F 812	1.All unlabeled undated expired food was discarded by Food Service Director, supervisor, or foreman immediately found in pantries, refrigerators, and on kitchen shelves. Kitchen utility instructed to record temperatures on a log for three compartment sinks and for dishwasher when thermo label is unavailable. Cooks, foreman, and supervisor informed to record refrigerator and freezer temperature log. Dented can moved to dented can area by Food Service Director. Can opener and food slicer was cleaned by kitchen staff. 2.All residents may be affected by not storing, preparing, distributing, and serving food in accordance with professional standards for food service safety. 3.Dietary Temperature Policy & Procedures updated to add 3 compartment sink temperature and log. Dietary Staff were in-service on sanitation, contamination, and reason for documentation. Monthly staff meetings reinforce logging temperatures of sinks, dishwashers, refrigerators, freezers, labeling food, throwing away unlabeled, undated food, removal of dented cans and cleaning slicers and can openers. The Dietary Supervisor / Kitchen Utility (KU) Foreman Daily Check List updated to reflect outdated items discarded and cabinet checks for expired items in pantries. Daily log had added 3 compartment sinks. Food Service Director and supervisors while completing rounds to observe proper log documentation and equipment cleanliness. Food Service Director to	

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 10/04/2021

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 812	Continued From page 19 dinner meals. On interview the KU stated to the surveyor, "Before I start dishwashing, I ensure the machine is meeting minimum temperature requirements for the wash and rinse. If the machine is not meeting the minimum requirements, then I report it to the supervisor." The surveyor requested to see the Dish Machine Temps log. The Dish Machine Temps log was observed to be completed up to the 14th of September for all meals with attached 1-Temp-Thermolabels. No temperatures were recorded for 7:00 AM, 11:00 AM and 4:00 PM on the 15th of September. No temperatures were recorded on the 16th of September for 7:00 AM, 11:00 AM and 4:00 PM. No temperature was recorded on the 17th of September. On interview the FSD stated, "I'm guessing they didn't do them on those days. It should be completed before each service and before initiating dish washing." 3. A Temperature log was attached to the front doors of refrigerator box #9. No internal temperatures of the refrigerator were recorded for the following dates: 9/10/2021 AM, 9/11/2021 AM and PM, 9/12/2021 AM and PM, 9/14/2021 PM, 9/15/2021 PM, 9/16/2021 PM and 9/17/2021 AM. The following was revealed according to the instructions on the log, "This log will be maintained for each refrigerator and freezer (both walk-in and reach-in units) in the facility. A designated food service employee will record the time, air-temperature, and their initials. The food service supervisor will for each facility will verify that food service employees have taken the required temperatures by visually monitoring food service employees and reviewing, initialing, and dating a sample of logs each month." 4. On a middle shelf of refrigerator box 7, a Styrofoam plate with clear plastic covering	F 812	review Daily Check List and report any deficit to administrator on corrections. 4.Food Service Director to report findings of the reviewed data collected and analysis on temperatures, labeling of food, any discarded food items, equipment cleanliness and use of dented can location to Quality Assurance Performance Improvement Committee on a quarterly basis for six months.	

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 10/04/2021

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 812	Continued From page 20	F 812		

contained sliced tomatoes and a bowl, with clear plastic covering, contained a garden type salad. No dates were observed on either food product. On interview the FSD stated, "They were from last night, but they're not dated so I'm throwing them away." In addition, a lower shelf had 2 sheet pans that contained 7 smoked fish platters. 2 of 7 smoked fish platters had no dates. The FSD stated, "They were from last night for Yom Kippur. They should have been dated. I'm trashing them." Review of the refrigerator box #7 Daily Freezer/Refrigerator Temperature Log revealed that no temperatures were recorded on 9/10/2021 AM, 9/11/2021 AM and PM, 9/12/2021 AM and PM, 9/16/2021 AM and PM and 9/17/2021 AM.

5. Review of the refrigerator Box #5 Daily Freezer/Refrigerator Temperature Log revealed that internal temperatures were not recorded for the following dates: 9/10/2021 AM, 9/11/2021 AM and PM, 9/12/2021 AM and PM, 9/15/2021 AM, 9/16/2021 AM and PM and 9/17/2021 AM.

6. The surveyor removed the can opener from its slot in the dairy prep area. The surveyor wiped their index finger on the upper can opener area next to the blade used to open cans. A black, greasy substance was observed on the surveyor's finger. On interview the FSD stated, a KU washes it once per week. The FSD removed the can opener and instructed a KU staff to clean it.

7. In Dairy Freezer #2 on an upper shelf, a blue plastic bag contained frozen cod. The bag was removed from its original container and was not labeled or dated. The FSD stated, "It's not labeled or dated. I'm throwing it away." On the same shelf, a bag contained frozen cinnamon rolls. The

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 10/04/2021

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 812	Continued From page 21	F 812		

bag was removed from its original container and had no dates. "They are going in the trash too. We are usually not in this situation."

8. In the Dairy Dry Storage area, a can of shredded sauerkraut on an upper rack of a multi-tiered rack, had a significant dent in the side of the can. The FSD stated The KU must have missed that one. The FSD removed the can to the designated dented can area.

9. A cleaned and sanitized meat slicer in the meat kitchen was observed on top of a counter. The meat slicer was observed to have unidentified food debris below the blade surface. The FSD and surveyor went to the break room and interviewed the cooks. When questioned whether they had used the meat slicer on this date, all staff responded "no". The FSD directed the cook to clean and sanitize the meat slicer.

On 9/23/2021 from 10:07 to 10:22 AM the surveyor, accompanied by the Licensed Practical Nurse/Unit Manager (LPN/UM #3), observed the following on the [redacted] Unit Pantry:

1. On the door of the refrigerator an 8-ounce whole milk had a manufacturer's "sell by" date of "SEP 21" On a lower shelf in the refrigerator, an [redacted] Italian Dressing bottle had a manufacturer's "best by" date of JUL/02/18'. On an upper shelf, an opened and exposed 8-ounce whole milk had a "sell by" date of SEP 18. On an upper shelf, a Styrofoam plate covered with clear plastic wrap contained an unidentified sandwich with sliced onions and a tomato slice also on the plate. The plate had no name or date. On the upper shelf a cardboard bowl with a white plastic lid that contained an

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 10/04/2021

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 812	Continued From page 22	F 812		

unidentified food had no name or date. On the same shelf, a small, plastic, clear container with a red plastic lid contained an unidentified white liquid. The container had no name or date.

2. In an upper cabinet, an apple was observed on the upper shelf. The apple was mushy to the touch. When interviewed LPN/UM #3 stated, The foodservice department is responsible for maintaining the pantry and discards any foods that are expired or unlabeled. Maintenance does daily temperature checks. The LPN/UM threw all the foods away in the presence of the surveyor.

On 9/27/2021 from 11:16 to 11:47 AM, the surveyors, accompanied by the FSD observed the following in the kitchen:

1. In refrigerator box 15 on a lower shelf, an aluminum pan contained sliced deli salami. The pan was dated "9/21. On interview the FSD stated, Sliced deli meats are good for three days. I'm throwing that in the trash.

The surveyor reviewed the facility policy titled Food Storage, reviewed date: 4/13. The following was revealed under the heading Policy Interpretation and Implementation:

9. Dented cans are stored on the bottom shelf in labeled areas for such.

10. All prepared food products stored in the refrigerator must be covered, labeled, and dated with the date and time that the food was prepared. All refrigerated products must be stored at 41 F or lower. All prepared food shall be discarded after 72 hours from the date the food was prepared.

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 10/04/2021

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 812	Continued From page 23	F 812		

11. The food services manager, or his/her designee, will check refrigerators for proper temperatures. The food services manager will maintain records of such information.

The surveyor reviewed the facility policy titled Sanitation, reviewed date: 4/13. The following was revealed under the heading Policy Interpretation and Implementation:

1. All kitchens, kitchen areas, and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects.

2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, and chipped areas that may affect their use or proper cleaning. Seals, hinges, and fasteners will be kept in good repair.

9. The food services manager will be responsible for scheduling cleaning of kitchen. Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment.

10. The surveyor reviewed the facility policy titled Foods Brought by Family/Visitors, R:4/2018. The following was revealed under the heading Policy Interpretation and Implementation:

6. All unopened perishable food must be kept in nursing unit refrigerator labeled with resident's name and date received. All opened perishable food will be destroyed.

10. Disposal of outdated food and cleaning

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 10/04/2021

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 812	Continued From page 24 procedures for these areas will follow facility food safety and sanitation practices and the task shall be completed by the dietary department. N.J.A.C. 8:39-17.2(g)	F 812		

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 10/04/2021

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) COMPLETE DATE
S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the state of New Jersey. This was evident for 11 of 14 day shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	1.Nursing staff schedules are completed a month in advance and offer overt time to CNAs to meet ratio. Voice Friend texting system, in person contact and calls to CNA□s are completed for the schedule. If a CNA calls out or any concern with the daily schedule then the Director of Nurses and or designee contact other CNA□s, Temporary CNA□s, agency CNA, or LPN/RN that available to work as a CNA are implemented to meet daily shift ratios. Notice went out to CNAs to see if interested in moving to day shift to help meet day shift ratio. Department heads, assistants and other non- staff may be	11/18/21

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 10/04/2021

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) COMPLETE DATE
S 560	Continued From page 1 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 8/29/21 through 9/4/21 and 9/5/21 through 9/11/21, the staffing to residents' ratios did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below: 8/29/21-9 CNAs for 91 residents on the day shift 8/30/21-11 CNAs for 91 residents on the day shift. 8/31/21-10 CNAs for 91 residents on the day shift. 9/1/21-9 CNAs for 91 residents on the day shift. 9/2/21-9 CNAs for 93 residents on the day shift. 9/3/21-10 CNAs for 93 residents on the day shift. 9/6/21-11 CNAs for 94 residents on the day shift.	S 560	assigned to supplement CNA□s in non nursing activity such as making a bed, transporting, passing out water as directed. 2.All residents may be affected by not meeting the staffing ratios on day shift. 3.Facility strives to meet CNA staffing ratios by implementing the following: New human resource staff hired and prioritizes CNA□s recruitment and expedited applications. Facility continues to advertise hiring CNAs online and other sources. Large hiring sign is posted in front on the main road. Human resources schedules job fairs and attend the CNA school job fairs to capture pending graduates. Five agencies are used for CNA staffing. A monetary system is designed to promoted CNAs with a sign on bonus, a referral bonus, overt time bonus, holiday or specials bonus, extra shift bonus, tiered wage rate for peak times, certification reimbursement, paid sponsored CNA classes for school and starting salary adjustment above $15. 4.Director of Nursing to check staffing daily and continue to work to meet the staffing ratios and will advise administrator of daily staffing issues. Human Resources to report weekly CNA applicants and status to Administrator and Quality Assurance Performance Improvement Committee on a quarterly basis. Director of Nursing will report weekly audits of daily staffing to Administrator and will report quarterly to Quality Assurance Performance Improvement Committee.	

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 10/04/2021

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) COMPLETE DATE
S 560	Continued From page 2 9/7/21-10 CNAs for 94 residents on the day shift. 9/8/21-11 CNAs for 94 residents on the day shift. 9/10/21-11 CNAs for 93 residents on the day shift. 9/11/21-11 CNAs for 93 residents on the day shift. During an interview with the surveyor on 9/28/21 at 10:26 AM, the Executive Director and Director of Nursing said they are aware of the staffing requirements.	S 560		