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	558100	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE ADULT DAY HEALTH CARE C	600 MAIN STREET ASBURY PARK, NJ 07712

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M 000	Initial Comments Type of Survey: Monitoring / Follow-up Census: 79 Sample: 4 On 9/3/2025, the Department of Health conducted a follow-up survey regarding the Attorney General's audit that was conducted on 8/12/2024. The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. 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 New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	M 000		
M 235	8:43F-3.3(d)(1) Administration (d) A policy and procedure manual(s) for the organization and operation of the facility shall be developed, implemented, and reviewed at intervals specified in the manual(s). Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility to representatives of the Department at all times. The manual(s) shall include at least the following: 1. A written statement of the program's philosophy and objectives and the services provided by the facility.	M 235		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/13/25

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M 235	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to maintain policies and procedures with the facility's name documented on them. This deficient practice was evidenced by the following: On 9/3/25 at 11:44 a.m., the Administrator provided the surveyor with the facility's Policy and Procedure manual for review. At 12:15 p.m., the surveyor reviewed the Policy and Procedure manual which revealed that the policies documented, "First Healthcare" on each page. The surveyor did not observe documentation which revealed the facility's name on the policies. At 12:22 p.m., the surveyor interviewed the Administrator and inquired about the title documented on the policies in the Policy and Procedure manual. The Administrator stated that "First Healthcare" was the facility's "mother company," and confirmed that the facility's name was not documented on the policies.	M 235		
M 351	8:43F-4.2(d) Participant Rights The telephone numbers in N.J.A.C. 8:43F-4.2(b)	M 351		

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M 351	Continued From page 2 and (c), shall be conspicuously posted in the facility at every public telephone and on all bulletin boards used for posting public notices. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to visibly post the required telephone numbers at every public telephone for all participants at the facility. This deficient practice was evidenced by the following: On 9/3/25 at 9:59 a.m., the surveyor requested the Director of Marketing (DOM) to show the surveyor the facility's public telephone that the participants used to make calls. At 10:01 a.m., the surveyor observed that the public telephone did not have the required telephone numbers posted nearby. The surveyor interviewed the DOM and inquired about the telephone numbers that were available to participants. The DOM stated that the staff members provided the participants with phone numbers upon request. At 2:26 p.m., the surveyor interviewed the Administrator and inquired about the public telephone and telephone numbers that were provided to the participants. The Administrator stated that the required phone numbers were not posted by the public telephone. The Administrator explained that the phone numbers were posted on the bulletin board in a different area at the facility.	M 351		

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M 393	Continued From page 3	M 393		
M 393	8:43F-6.1(b) General Services The facility, at a minimum, shall provide the following services directly in the facility: nursing, dietary, activities, pharmaceutical, and social work. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide social work services to all participants at the facility. This deficient practice was evidenced by the following: On 9/3/25 at 11:34 a.m., the surveyor interviewed the Director of Social Services (DSS) and inquired about how long she had been employed at the facility. The DDS stated that she started working at the facility in NJ Ex Order 26. 4B1. The DSS confirmed that she was the only social worker at the facility, and she did not know when the last social worker left prior to her start date. At 11:44 a.m., the Administrator provided the surveyor with the facility's staff list. The surveyor reviewed the staff list provided to the surveyor which revealed that the DSS' NJ Ex Order 26. 4B1 . At 2:26 p.m., the surveyor interviewed the Administrator and inquired about the social work services that the facility provided to the participants prior to the current DSS' start date in NJ Ex Order 26. 4B1. The Administrator stated that the facility did not have a social worker prior to the DSS' employment in NJ Ex Order 26. 4B1.	M 393		

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M 393	Continued From page 4 During the interview with the Administrator, the surveyor requested the Administrator to provide documentation regarding the social workers who were employed at the facility between [NJ Exec Order 26.4b] of [NJ Exec Ord] and [NJ Exec O] of [NJ Exec Orde] On 9/4/25 at 12:35 p.m., the Administrator provided the surveyor, via email, with the start and end dates of the previous social workers' who were employed at the facility between [NJ Exec Orde] and [NJ Exec Orde] The Administrator documented in the email, sent on 9/4/25 to the surveyor, that the facility had a social worker between [NJ Exec Order 26.4b1] and [NJ Exec Order 2] and then had another social worker between [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b] Surveyor review of the start and end dates of the three (3) social workers, revealed that the facility did not always have a social worker between [NJ Exec Ord] and [NJ Exec Orde] The findings were as follows: 1. The facility did not have a social worker between NJ Exec Order 26.4b1 for over [NJ Ex Order 26. 4B1] months. 2. The facility did not have a social worker between NJ Exec Order 26.4b1 for over [NJ Ex Order 26. 4b] month. The surveyor reviewed an undated facility policy titled, "DESIGNATION OF SOCIAL WORKER," which revealed, " ... The center shall designate a social worker who shall be responsible for the direction, provision, and quality of the social work services ... A social worker shall provide social work services in the center for at least thirty minutes per week per participant equivalent ..."	M 393		

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M 423	Continued From page 5	M 423		
M 423	8:43F-6.3(f) General Services Employee health records as required by these rules shall be maintained for each employee. Employee health records shall be confidential and kept separate from personnel records and shall include documentation of all medical screening tests performed and the results. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to maintain health records which included all medical screenings performed, including physical examinations and/or NJ Ex Order 26. 4B1 screenings, for 4 of 4 employees, Employee #s 1, 2, 3, and 4. This deficient practice was evidenced by the following: On 9/3/25 at 12:14 p.m., the surveyor reviewed the staff list and requested the Administrator to provide the personnel health files of the above four (4) employees. At 2:26 p.m., the Administrator provided the surveyor with copies of the 4 employees' most recent physical examinations and [redacted] screenings. The surveyor requested the physical examinations and [redacted] screenings that were completed upon hire for the 4 employees. On 9/4/25 at 12:35 p.m., the Administrator provided the surveyor, via email, with the 4 employees' physical examinations and [redacted] screenings upon their hire. The surveyor reviewed the provided employees' documents and observed that some of the physical	M 423		

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M 423	Continued From page 6 examinations and [NJ Ex O] screenings were not in accordance with the timeframes upon the employees' [NJ Ex Order 26. 4B1] (DOH). The findings were as follows: 1. Employee #1 who was [NJ Ex Order 26. 4B1], had a "Nursing Assessment" dated [NJ Exec Order 2], completed by a Registered Nurse (RN) to allow the employee to work for 30 days per the facility's policy. However, Employee #1 did not have an employment physical, completed by a physician, unti [NJ Exec Order 26.] over [NJ Ex] days later. 2. Employee #2 who was [NJ Ex Order 26. 4B1], had a physical examination dated [NJ Exec Order 26.4], over two (2) years prior to the employee's DOH. Surveyor review of Employee #2's [NJ Ex O] screening documentation revealed that the employee's date of Last [NJ Ex O] screening or [NJ Ex Order 26.] was [NJ Exec Order 26.4]. There was no further documentation or test results regarding the [NJ Ex O] screening that was completed on [NJ Exec Order 26.4]. 3. Employee #3 who was [NJ Ex Order 26. 4B1], had a "Nursing Assessment" dated [NJ Exec Order 26.4b] completed by a RN. However, Employee #3 did not have an employment physical, completed by a physician, until [NJ Exec Order 26.4], over [NJ Ex Order 26. 4] year later. 4. Employee #4 who was [NJ Ex Order 26. 4B1], had a Driver Fitness Determination examination dated 5/2/11. However, the examination was not signed by the Medical Examiner and did not include the Medical Examiner's contact information. The surveyor observed that Employee #4 did not have a physical examination completed on the "Employee Physical Examination" form, which was specified in the facility's policy.	M 423		

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M 423	Continued From page 7 On 9/3/25 at 2:26 p.m., the surveyor interviewed the Administrator and inquired about the employee physical examinations and [redacted] screening. The Administrator stated that all employees received a [redacted] screening and physical examination upon hire. The Administrator also stated that each employee was expected to have a physical examination every three (3) years after the initial examination. The surveyor reviewed an undated facility policy titled, "PERSONNEL FILE," which indicated, " ... Copies of all employee medical records, such as physical examinations and any testing are kept in a separate file." The surveyor reviewed an undated facility policy titled, "PHYSICAL EXAMINATION," which revealed, " ... To satisfy this requirement, an employee must: A. Produce documentation of a physical examination completed within 14 days prior to their hire date. OR B. Receive a physical examination upon their hire date. AND C. If the new employee receives a nursing assessment upon hire, the physical examination may be deferred up to 30 days ... The employee's physician or other designated professional must complete a copy of the attached 'Employee Physical Examination' ..." The surveyor reviewed another undated facility policy titled, "TUBERCULOSIS TESTING," which revealed, " ... each employee must receive a tuberculosis test upon hire ... The only exceptions shall be employees or participants with documented negative two-step Mantoux skin results ... within the last year ..."	M 423		

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M 619	Continued From page 8	M 619		
M 619	8:43F-14.4(b) Physical Plant Requirements The main entrance of the facility shall have a lobby/reception area. This area shall contain space for waiting, a public telephone, a drinking fountain or bottled water, and space for wheelchair storage. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to have a lobby/reception area that contained a waiting space for participants, a public telephone, and a space for wheelchair storage for all participants. This deficient practice was evidenced by the following: On 9/3/25 at 9:00 a.m., the surveyor observed a desk located across from the facility's entrance, which was also located near the Activity Room. The surveyor did not observe a waiting space for participants or wheelchair storage located near the desk. At 9:59 a.m., the surveyor interviewed the Director of Marketing (DOM) and inquired about the reception area. The DOM confirmed that the desk, located across from the facility's entrance was the reception desk. Additionally, the DOM stated that the phone located at the reception desk was not a public telephone but participants could use it if necessary. At 2:26 p.m., the surveyor interviewed the Administrator and inquired about the reception area. The Administrator confirmed that there was no waiting area, with seating, that was in the	M 619		

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M 619	Continued From page 9 reception/lobby space of the facility.	M 619		
M 633	8:43F-14.6 Physical Plant Requirements A janitor's closet shall be provided, on each floor or immediately accessible, which shall contain a service sink and storage for housekeeping supplies and equipment. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide a janitor's closet that was immediately accessible for staff members. This deficient practice was evidenced by the following: On 9/3/25 at 10:26 a.m., during a tour of the facility with the Administrator, the surveyor observed a locked closet that had a "JANITOR'S CLOSET" sign on the door. The Administrator confirmed that the closet was where the cleaning supplies were stored. During continued surveyor interview with the Administrator, the Administrator stated that there was a contracted cleaning service that cleaned the facility and had access to the janitor's closet. The Administrator informed the surveyor that the cleaning company's employee was not yet at the facility. The Administrator could not unlock the closet since she did not have a key to the janitor's closet. The surveyor reviewed an undated facility policy titled, "HOUSEKEEPING AND MAINTENANCE,"	M 633		

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M 633	Continued From page 10 which revealed, " ... The center will be maintained in a clean and sanitary fashion at all times ..."	M 633		
M 645	8:43F-14.9(b)(1-3) Physical Plant Requirements (b) The following shall be provided for pharmaceutical services: 1. A dispensing area with a handwashing facility; 2. A locked storage cart or locked cabinets; and 3. A separate lockable refrigerator or a locked box within a refrigerator for storage of medications. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain a lock on the medication refrigerator in the Nursing Office for all participants. This deficient practice was evidenced by the following: On 9/3/25 at 10:07 a.m., the surveyor observed the medication refrigerator without a lock. At 10:08 a.m., the surveyor interviewed the Director of Nursing (DON) and inquired about the locking mechanism on the medication refrigerator. The DON confirmed that there was	M 645		

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M 645	Continued From page 11 no lock on the medication refrigerator. The surveyor reviewed an undated facility policy titled, "DAILY INSPECTIONS," which indicated, " ... The administrator or designee will do a visual inspection on a daily basis to ensure that all potential health and/or safety problems are addressed on a timely basis ... The administrator or designee will complete the attached daily inspection checklist ... Medication Cabinets are locked ..."	M 645		
M 651	8:43F-14.10(a)(1)(i) Physical Plant Requirements (a) Each adult facility shall provide a quiet room or a separate, quiet area for participants who wish to rest or recline. The quiet room/area shall not be counted as activity or dining space. 1. The facility shall provide at least one item of comfortable furniture, such as a bed, lounge, recliner, or equivalent, selected in accordance with assessments of participants' needs to rest or recline, for every 10 adult day health services participant equivalents, calculated on the basis of the licensed capacity. This comfortable furniture shall be available for use in the quiet room/area. i. A minimum of 40 square feet shall be provided for each bed, lounge, recliner, or equivalent.	M 651		

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M 651	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide a quiet room/area, separate from the activity space, for all participants. This deficient practice was evidenced by the following: On 9/3/25 at 9:45 a.m., the surveyor observed the facility's quiet area had partitions on wheels that surrounded two (2) of the four (4) sides of the quiet area. The surveyor observed that the noise from the activity and dining spaces throughout the facility was clearly audible from the quiet area. The surveyor also observed that there was a large television with the speaker's volume turned up within the quiet space. At 1:24 p.m., while the surveyor was in the Conference room, the surveyor heard an unsampled participant become frustrated and upset with the noise level while he/she was in the quiet area. The surveyor went to the quiet area and observed that the unsampled participant was upset with another participant who was listening to music without headphones. At 2:26 p.m., the surveyor interviewed the Administrator and inquired about the quiet area. The Administrator stated that the quiet area was located within the partitions, which separated the space from the rest of the facility. The Administrator explained that if a participant wanted a quiet space to relax, the participants could utilize the Conference room or Physical Therapy room. The Administrator clarified that the	M 651		

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M 651	Continued From page 13 Conference room and the PT room could be utilized as a quiet space for participants as long as the rooms were not in use.	M 651		
M 689	8:43F-14.17(f)(g) Physical Plant Requirements (f) Drills of emergency plans shall be conducted at least four times a year and documented, including the date, hour, description of the drill, participating staff, and signature of the person in charge. The four drills shall include at least one drill for emergencies due to fire. (g) The facility shall conduct at least one drill per year for emergencies due to another type of disaster, such as storm, flood, other natural disaster, bomb threat, or nuclear accident. All staff shall participate in at least one drill annually, and program participants may take part in drills. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to maintain documentation of emergency drills, which included the specific date of the drill and all participating staff members. This deficient practice was evidenced by the following. On 9/3/25 at 1:44 p.m., the surveyor requested the Administrator to provide documentation regarding the facility's fire drills from 2023 to	M 689		

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M 689	Continued From page 14 2025. The Administrator informed the surveyor that she believed the 2023 fire drills documentation was in storage, outside of the facility since documentation was sent to storage after one year. The surveyor reviewed the fire drills documentation provided by the Administrator from January of 2024 to August of 2025. The surveyor observed that the dates of the drills that were recorded only included the month and the year of the drill and there was no specific date(s) documented. Additionally, the surveyor observed that the same four to six signatures were documented under the section of the form labeled, "Staff that participated:" for each of the 20 fire drill documents provided to the surveyor. At 2:26 p.m., the surveyor interviewed the Administrator and inquired about the fire drills. The Administrator stated that she documented the month and year on the forms and stated that only staff members who were department heads signed off on the fire drills. The surveyor reviewed an undated facility policy titled, "ADMINISTRATOR'S RESPONSIBILITIES," which indicated, " ... The administrator shall be responsible for, but not limited to, the following: ... Ensuring the provision of staff orientation and staff education ..."	M 689		
M 701	8:43F-15.3(a)(1) Medical Records (a) The participant's complete medical record shall include, but not be limited to, the following: 1. Participant identification data, including name, date of admission, address, date	M 701		

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	558100	A. BUILDING: _____ B. WING _____	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 701	Continued From page 15 of birth, race, religion (optional), sex, referral source, payment plan, marital status, and the name, address, and telephone number of the person(s) to be notified in an emergency, and travel directions to the participant's home. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to maintain a current participant photograph, signed participant rights, and/or proper emergency contact information for 4 of 4 participants reviewed, Participant #s 1, 2, 3, and 4. This deficient practice was evidenced by the following: On 9/3/25 at 9:08 a.m., the surveyor interviewed the Administrator and inquired about the system in place for the participant records. The Administrator stated that all participant records were in the electronic medical record (EMR) system. The Administrator added that if there was a paper document for the participant, it was scanned into the EMR. 1. At 12:46 p.m., the surveyor reviewed Participant #1's EMR, which indicated that the participant was [redacted] *NJ Ex Order 26. 4B1* [redacted]. Surveyor review of Participant #1's EMR revealed that there was no photograph of the participant, signed participant rights, or address of the	M 701		

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M 701	Continued From page 16 participant's emergency contact included in the EMR. 2. At 12:52 p.m., the surveyor reviewed Participant #2's EMR, which indicated that the participant was *NJ Ex Order 26. 4B1* [redacted]. Surveyor review of Participant #2's EMR revealed that there was no photograph of the participant or address of the participant's emergency contact included in the EMR. The surveyor observed Participant #2's signed participant rights in an attachment within the EMR. 3. At 12:58 p.m., the surveyor reviewed Participant #3's EMR, which indicated that the participant was *NJ Ex Order 26. 4B1* [redacted]. Surveyor review of Participant #3's EMR revealed that there was no signed participant rights or address of the participant's emergency contact included in the EMR. 4. At 1:03 p.m., the surveyor reviewed Participant #4's EMR, which indicated that the participant was *NJ Ex Order 26. 4B1* [redacted]. Surveyor review of Participant #4's EMR revealed that there was no photograph of the participant, signed participant rights, or emergency contact included in the EMR. At 2:26 p.m., the surveyor interviewed the Administrator regarding the above concerns. The Administrator stated that the facility used to have polaroid pictures of the participants and confirmed that each participant should have had a digital picture in his/her EMR. During continued surveyor interview with the	M 701		

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M 701	Continued From page 17 Administrator, the Administrator stated that the signed participant rights should have been located within the EMR; however, she was unable to specify the location of the signed participant rights. Additionally, the Administrator stated that the social work services and the nursing department were responsible for ensuring that the participants' emergency contact information was completed. The surveyor reviewed an undated facility policy titled, "FORMAT AND STORAGE OF MEDICAL RECORDS," which revealed, " ... Each medical record will contain, but not be limited to, the following: ... All participant identifying information ... Documentation that participant rights were explained to the participant ..." Additionally, the surveyor reviewed an undated facility policy titled, "PARTICIPANT PHOTOGRAPHS," which revealed, " ... Each participant will have a current photograph placed in their medical record ..."	M 701		
M 805	8:43F-16.5(a)(b)(c) Infection Control, Santation, Housekeeping (a) The facility shall provide and maintain a sanitary and safe environment for participants. (b) The facility shall provide housekeeping and pest control services. (c) Written objectives, policies, a procedure manual, an organizational plan, and a quality improvement program for housekeeping, sanitation, and safety services shall be developed and implemented.	M 805		

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M 805	Continued From page 18	M 805		

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined that the facility failed to maintain a sanitary and safe environment for all participants at the facility. This deficient practice was evidenced by the following:

1. On 9/3/25 at 9:25 a.m., the surveyor observed two (2) long, lights in the Conference room that had debris and [NJ Ex Order 26. 4B1] in the fixtures. Additionally, the surveyor observed stained ceiling tiles in the Conference room.

At 9:26 a.m., the surveyor observed dirt and dust on the base trim of the wall, next to the door of the Conference room. Additionally, the surveyor observed [NJ Ex Order 26. 4B1] [NJ Ex Order 26.4(b] on the wall that was next to the door of the Conference room.

At 9:42 a.m., the surveyor observed the light fixture located above the Quiet Area with debris present along the perimeter of the fixture's panels.

At 9:44 a.m., the surveyor observed two ceiling fans, above the Quiet Area, with an excess amount of dust on the blades of the fans.

At 9:49 a.m., the surveyor observed a plastic fork on the floor of the Dining Room. Additionally, the surveyor observed dirt and [NJ Ex Order] [NJ Ex Order] on the far wall and the closet doors in the Dining Room.

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M 805	Continued From page 19 At 10:20 a.m., the surveyor observed dirty kitchen floors and pipes, under the dishwashing sink in the kitchen. At 10:35 a.m., the surveyor observed damaged walls and flooring in the women's restroom that was located across from the Quiet Area. At 11:34 a.m., the surveyor observed two (2) large cracks on the wall of the social worker's office. At 2:26 p.m., the surveyor interviewed the Administrator and inquired about the cleaning and maintenance of the facility. The Administrator stated that a contracted cleaning company was responsible for cleaning the facility. Additionally, the Administrator explained that she called or emailed the cleaning company for any concerns regarding the facility's cleanliness. During continued surveyor interview with the Administrator, the Administrator stated that she was unsure who was responsible for the maintenance of the ceiling tiles, since the facility's building was rented by a landlord. 2. On 9/3/25 at 9:34 a.m., the surveyor observed two (2) sets of ceiling lights in the Conference room that had light bulbs that did not work. At 9:42 a.m., the surveyor observed a large light fixture, directly above the Quiet Area, which had exposed light bulbs that did not have paneling which covered the lights. At 9:44 a.m., the surveyor observed one (1) of the two (2) fans, located above the Quiet Area, which had a string-like material draped over one of the	M 805		

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M 805	Continued From page 20 fan's blades. At 9:54 a.m., the surveyor observed a white, water cooler in the back of the facility which was not in use by participants that was covered in dirt and had a [redacted] in it. The Activities Director, who accompanied the surveyor to the back of the facility stated that the water cooler was not in use. At 10:35 a.m., the surveyor observed exposed sub-flooring and missing tiles on the floor of the women's restroom that was located across from the Quiet Area. At 2:26 p.m., the surveyor interviewed the Administrator and inquired about the maintenance of the facility's equipment, lighting fixtures and exposed lighbulbs throughout the facility. The Administrator stated that the facility's electrician was responsible for changing the lightbulbs and stated that the light fixtures over the Quiet area had always been exposed. Additionally, the Administrator, stated that the white, water cooler was not in use and could not recall the last time it was used. 3. On 9/3/25 at 9:41 a.m., the surveyor observed three (3) bicycles, a scooter, and a trash bin between the partition of the Quiet area and the railing of the ramp. The surveyor observed that the passageway in between the Quiet area and ramp was obstructed by the above five objects. At 10:26 a.m., the surveyor observed many boxes and objects placed on the floor of the dry Food storage closet. The surveyor observed that the access to the lower shelves of the shelving units and the passageway to the door in the closet was obstructed by boxes and objects that were stored on the floor.	M 805		

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M 805	Continued From page 21 At 2:26 p.m., the surveyor interviewed the Administrator and inquired about the bicycle storage. The Administrator stated that participants usually kept their bikes outside and sometimes placed their bicycles along the railing by the Quiet area. The surveyor also inquired about the boxes in the dry Food storage closet and the Administrator stated that it was cleared out and it looked a lot better now, than it did before. 4. On 9/3/25 at 9:26 a.m., the surveyor observed an unsecured extension cord that was hanging down the wall of the Conference room that was not plugged in to a power outlet. At 9:47 a.m., the surveyor observed a power cord that was hanging down from a television and the plug was not attached to an outlet and was on the floor. At 9:48 a.m., the surveyor observed a surge protector with spaces for multiple cords to be plugged into, located in the Dining Room. The surveyor observed that the surge protector was suspended in the air and the power cords were pulling it off the floor. At 10:09 a.m., the surveyor observed an extension cord that was draped over the soap and paper towel dispensers in the Nursing Office. The surveyor also observed an air freshener that was plugged into the extension cord. At 2:26 p.m., the surveyor interviewed the Administrator and inquired about the extension cords and unsecured wires/cords throughout the facility. The Administrator denied that there were	M 805		

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M 805	Continued From page 22 extension cords in the facility. The Administrator stated that there were nails to secure the cords and power surge strips. 5. On 9/3/25 between 10:11 a.m. and 10:16 a.m., the surveyor observed multiple food items that were removed from their original packaging and did not have the expiration dates labeled. The surveyor interviewed a kitchen staff member who confirmed that the following food items were not labeled and/or did not have the expiration dates documented on the packaging. The findings were as follows: A container of potato salad that did not have an expiration date or label documented on the container. 2 bags of sausage links that did not have an expiration date of label documented on the bags. A drawer filled with individually wrapped [redacted] butter squares, which did not have the expiration date documented. A drawer filled with single-serve [redacted] cheese spread cups, which did not have the expiration date documented. 2 packs of frozen waffles that did not have an expiration date or label documented on the packages. 14 packs of frozen pancakes that did not have an expiration date or label documented on the packages. At 10:12 a.m., the surveyor interviewed the kitchen staff member and inquired about the process of labeling food items in the kitchen. The	M 805		

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M 805	Continued From page 23 kitchen staff member stated that she usually labeled all the food items and the drawers which contained the butter squares and cream cheese cups with the expiration dates. 6. On 9/3/25 at 10:21 a.m., the surveyor observed that there was an unlocked cabinet in the kitchen that contained [NJ Exec Order 2] disinfectant spray, [NJ Exec Orde] cleanser, and [NJ Exec Order 26.4b1] cleaner. At 10:22 a.m., the surveyor interviewed the same kitchen staff member and inquired about the cleansers in the kitchen cabinet. The staff member confirmed that the cabinet, which contained the cleansers, was not kept locked. 7. On 9/3/25 at 9:56 a.m., the surveyor observed a gallon of paint and two (2) quarts of paint that were in the Physical Therapy (PT) room, between two plastic cabinets. At 10:21 a.m., the surveyor observed [NJ Ex Order 26. 4B1] Charcoal Lighter Fluid that was stored in a wooden, kitchen cabinet. At 2:26 p.m., the surveyor interviewed the Administrator and inquired about the cans of paint located in the PT room and the lighter fluid observed under the kitchen cabinet. The Administrator stated that she was unaware of the paint cans in the room and explained that since the PT service rented the room, it was their paint. The Administrator stated that she was not aware of the lighter fluid in the kitchen cabinet. 8. During the Office of Inspector General's (OIG's) visit at the facility on 8/12/24, the auditor observed food in the medication refrigerator. The OIG auditor also observed medications for multiple participants that was kept in an unlocked	M 805		

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M 805	Continued From page 24 cabinet not designated for medication. The surveyor reviewed an undated facility policy titled, "DAILY INSPECTIONS," which revealed, " ... In order to support a health and safe environment for our staff and clients, the administrator or designee will do a visual inspection on a daily basis to ensure that all potential health and/or safety problems are addressed on a timely basis ... Food is stored properly, labeled and dated ... Cleaning materials are stored in locked supply closet ... Storage areas/closets are clean, orderly and free of hazardous objects ... No storage on floor ..." Additionally, the surveyor reviewed an undated facility policy titled, "DISPOSABLE FOOD ITEMS," which revealed, " ... All food items shall be labeled with a use by date when they are opened and used for the first time ..."	M 805		
M 807	8:43F-16.6(a) Infection Control, Santation, Housekeeping A written work plan for housekeeping operations shall be established and implemented, with categorization of cleaning assignments as daily, weekly, monthly, or annually within each area of the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to establish and implement monthly and annual cleaning schedules. This deficient practice was evidenced by the following:	M 807		

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M 807	Continued From page 25 On 9/3/25 at 11:44 a.m., the Administrator provided the surveyor with the facility's Policy and Procedure manual (PPM) for review. At 12:15 p.m., the surveyor reviewed the PPM and observed that the cleaning schedule only documented daily and weekly cleaning tasks and did not include monthly or annual cleaning schedules. At 1:44 p.m., the surveyor interviewed the Administrator and inquired about the cleaning schedules in the PPM. The Administrator stated that the only cleaning schedules for the facility were in the PPM. The surveyor reviewed an undated facility policy titled, "CLEANING SCHEDULE," which revealed, " ... A schedule will be developed to ensure that all areas are cleaned on a regular basis ... Daily ... Weekly (or as needed) ..."	M 807		
M 825	8:43F-17.1(c)(d)(e) Transportation Services (c) Vehicles shall be maintained in safe operating order. (d) The facility shall maintain insurance on the vehicles. (e) The facility shall comply with all applicable Department of Transportation rules promulgated under N.J.S.A. 39:1-1 et seq.	M 825		

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M 825	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain its vehicles in safe operating order for 3 of 3 facility vehicles reviewed, Vehicles #1, #2, and #3. This deficient practice was evidenced by the following: On 9/3/25 at 10:28 a.m., the surveyor requested the Administrator to escort the surveyor to the facility's vehicles to be inspected. The Administrator stated that the facility had nine (9) vehicles, however some of the vehicles were actively transporting participants at the time of the surveyor's request to observe the vehicles. At 10:30 a.m., the surveyor observed Vehicle #1, which had an inspection sticker that expired as of June of 2024. The surveyor observed that the vehicle's driver was waiting for participants who had an appointment outside of the facility. At 10:31 a.m., the surveyor observed Vehicle #2 and Vehicle #3 that were parked in the facility's parking lot, which had inspection stickers that expired as of September of 2024. The Administrator stated that both vehicles were not in use, but she could not specify the last time either vehicle was driven. At 2:26 p.m., the surveyor interviewed the Administrator and inquired about the 3 vehicles' expired inspection stickers. The Administrator stated that the inspections should have been completed, and it was the drivers' responsibilities	M 825		

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M 825	Continued From page 27 to have each vehicle inspected on time. The surveyor reviewed an undated facility policy titled, "DRIVERS," which revealed, " ... Driver's responsibilities include, but are not limited to: ... The driver will be responsible for all aspects of vehicle maintenance."	M 825		

POC# 2 received 10/28/25
Accepted on 10/29/25

Jersey Shore
ADULT DAY HEALTH CARE CENTER
600 MAIN STREET, ASBURY PARK, NJ 07712
TEL: (732) 869-9090 FAX: (732) 988-2803

PLAN OF CORRECTION (POC)

M 235 8:43F-3.3(d) (1) Administration

1. CORRECTIVE ACTION

Current policies and procedures revised to include facility's name initiated on September 5, 2025, and anticipated to be completed on October 30, 2025.

In-service on September 5, 2025, by Corporate Director of Nursing for staff responsible for policy development and updates on standardized policy and procedure template including the requirement for facility-specific identification.

2. IDENTIFY OTHERS

All clients in attendance had the potential to be affected by this practice.

3. SYSTEMIC CHANGES

Annual in-service by Corporate Director of Nursing for staff responsible for policy development and updates on standardized policy and procedure template including the requirement for facility-specific identification.

"Standardized policy and procedure template" added to "Personal Information" sheet.

4. QUALITY ASSURANCE

Annual audit of policies and procedures, by Administrator or designee, to ensure policy & procedures remain compliant with documentation standards to include the facility's name on them.

Annual review of in-services in November as part of the Quality Improvement program (made up of the Nursing, Social Work, Activity Department Heads, and the Administrator) using the "Review Employee Credentials and In-Services Using the Personal Information" to ensure that staff responsible for policy development and updates has been in-serviced.

Completion Date: October 30, 2025

approved 10/29/25

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PLAN OF CORRECTION (POC)

M 351 8:43F-4.2(d) Participant Rights

1. CORRECTIVE ACTION

A list of all required telephone numbers has been posted at the public telephone in the facility on September 3, 2025.

2. IDENTIFY OTHERS

All clients in attendance had the potential to be affected by this practice.

3. SYSTEMIC CHANGES

The facility's "Daily Inspection Checklist," performed by the Administrator or designee, has updated on September 5, 2025, to include verification that the telephone posting remains posted at the public telephone in the facility.

4. QUALITY ASSURANCE

The Daily Inspection Log is reviewed 6 (six) times a year as part of the Quality Improvement Program by the Quality Improvement Committee made up of the Nursing, Social Work, Activity Department Heads, and the Administrator. Verification that the required telephone numbers remain posted at the public telephone in the facility will be reviewed at this time.

Completion Date: October 30, 2025

approved
10/29/25

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PLAN OF CORRECTION (POC)

M 393 8:43-F-6.1(b) General Services

1. CORRECTIVE ACTION

Social Worker hired on May 27, 2025.

2. IDENTIFY OTHERS

All the clients in attendance had the potential to be affected by this practice.

3. SYSTEMIC CHANGES

Administrator will schedule a full-time social worker to ensure adequate social worker hours.

4. QUALITY ASSURANCE

Employee schedules will be reviewed by the Administration every Friday for the coming week to ensure appropriate social work hours for clients expected to attend.

Completion Date: September 5, 2025

[redacted] approved 10/29/25

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PLAN OF CORRECTION (POC)

M 423 8:43F-6.3(f) General Services

1. CORRECTIVE ACTION

Employee 1 Employee physical up to date
Employee 2 [redacted] Screening and Employee Physical up to date
Employee 3 [redacted] Screening and Employee Physical up to date
Employee 4 has a current Driver Fitness Determination signed by the Medical Examiner and includes the Medical Examiner's contact information.

Human resources and supervisory staff involved in hiring, retrained on September 5, 2025, by the Corporate Director of Nursing regulatory requirements for pre-employment health screenings.

2. IDENTIFY OTHERS

All the clients in attendance had the potential to be affected by this practice.

Employee personnel files audited from September 5, 2025, ensuring Employee Physical Examination or Driver Fitness Determination form and [redacted] screenings are timely and up to date.

3. SYSTEMIC CHANGES

New employees may not begin work or be on the schedule without a documented Employee Physical Examination or Driver Fitness Determination form and completed [redacted] screening.

Physical Examinations Policy for employees updated on September 5, 2025 to include that a signed Driver Fitness Determination form may be accepted in lieu of "Employee Physical Examination" and that new employees may not begin work or be on the schedule without a documented Employee Physical Examination or Driver Fitness Determination form and completed [redacted] screening.

4. QUALITY ASSURANCE

The Administrator or designee will conduct a monthly audit of new employee file(s) hired within that month to ensure that Employee Physical Examination or Driver Fitness Determination forms and [redacted] screenings have been completed timely and are up to date.

Completion Date: October 30, 2025 [redacted] approved 10/29/25

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PLAN OF CORRECTION (POC)

M 619 8:43F-14.4(b) Physical Plant Requirements

1. CORRECTIVE ACTION

Wheelchair storage area designated to the right of the entrance doors when facing the doors from the inside on October 9, 2025.
An additional telephone added to the reception desk designated as a public telephone on October 9, 2025.
A seating area added when entering the facility on October 9, 2025.
A sign informing guests that "Water is available upon request" hung by the seating area on October 9, 2025.
Employees in-serviced, by the Administrator, regarding changes to facility areas including wheelchair storage, seating area, public telephone, and available water on October 9, 2025.

2. IDENTIFY OTHERS

All clients in attendance had the potential to be affected by this practice.

3. SYSTEMIC CHANGES

The "Daily Inspection Log" performed by the Administrator or designee, revised on October 9, 2025, to include a section for documenting that the facility has a waiting space for participants, wheelchair storage, and a public telephone.

Annual in-service regarding lobby/reception area including wheelchair storage, seating area, public telephone, and available water will be done by the Administrator or designee.

4. QUALITY ASSURANCE

The "Daily Inspection Log" is reviewed 6 (six) times a year as a part of the Quality Improvement Program by the Quality Improvement Committee, made up of the Nursing, Social Work, Activity Department Heads, and the Administrator. Verification that the facility has a waiting space for participants, wheelchair storage, and a public telephone will be reviewed at this time.

Annual review of in-services in November as part of the Quality Improvement program using the "Review Employee Credentials and In-Services Using the Personal Information" to ensure that an annual in-service regarding lobby/reception area including wheelchair storage, seating area, public telephone, and available water took place.

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Completion Date: October 30, 2025 [redacted] approved 10/20/25

PLAN OF CORRECTION (POC)

M 633 8:43F-14.6 Physical Plant Requirements

1. CORRECTIVE ACTION

A copy of the janitor's closet key obtained from the facility's cleaning company on September 5, 2025.

Employees in-serviced, by the Administrator, regarding the location of the janitor's closet key on September 5, 2025.

2. IDENTIFY OTHERS

All clients in attendance had the potential to be affected by this practice.

3. SYSTEMIC CHANGES

A labeled key box in the administrator's office has been assigned for storage of the janitor's closet key.

The "Daily Inspection Log" performed by the Administrator or designee revised on September 5, 2025, to include a section for documenting the janitor's closet key is in the labeled key box in the administrator's office.

4. QUALITY ASSURANCE

The "Daily Inspection Log" is reviewed 6 (six) times a year as a part of the Quality Improvement Program by the Quality Improvement Committee (made up of the Nursing, Social Work, Activity Department Heads, and the Administrator). Verification that the janitor's closet key is in the labeled key box in the administrator's office will be reviewed at this time.

Completion Date: October 30, 2025 [redacted] approved 10/20/25

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PLAN OF CORRECTION (POC)

M 645 8:43F-14.9(b) (1-3) Physical Plant Requirements

1. CORRECTIVE ACTION

Lock obtained and medication refrigerator securely locked on September 3, 2025.

2. IDENTIFY OTHERS

All clients in attendance had the potential to be affected by this practice.

3. SYSTEMIC CHANGES

The "Daily Inspection Log" performed by the Administrator or designee, revised on September 5, 2025, to include a section for documenting Medication Refrigerator is locked.

4. QUALITY ASSURANCE

The "Daily Inspection Log" is reviewed 6 (six) times a year as a part of the Quality Improvement Program by the Quality Improvement Committee (made up of the Nursing, Social Work, Activity Department Heads, and the Administrator). Verification that the Medication Refrigerator is being kept locked reviewed at this time.

Completion Date: October 30, 2025

[redacted] approved 10/20/25

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PLAN OF CORRECTION (POC)

M 651 8:43F-14.10(a)(1)(c) Physical Plant Requirements

1. CORRECTIVE ACTION

The partitions removed and the quiet area moved to the room near the Social Worker's office that has doors that may be closed to keep the noise out on October 9, 2025.

No televisions will be utilized in the Quiet area.

A sign reading "Quiet Zone: To maintain a peaceful environment, please refrain from using cellphones or playing music without headphones" hung in Quiet Area on October 9, 2025.

Staff in-serviced by the Administrator on the switching of the Quiet Area and Activity area and includes instruction to monitor the quiet area to ensure that noise level is at a minimum, and participants are not listening to music or watching television (on cellphones) without headphones on October 9, 2025.

2. IDENTIFY OTHERS

All clients in attendance had the potential to be affected by this practice.

3. SYSTEMIC CHANGES

The doors of the "new' Quiet Area can be closed to block out any noise level from the adjacent activity room.

A sign reading "Quiet Zone: To maintain a peaceful environment, please refrain from using cellphones or playing music without headphones" hung in Quiet Area on October 9, 2025.

Annual in-service by the Administrator or designee for staff regarding the ongoing expectations to maintain a respectful and peaceful environment of the Quiet Area and active monitoring the designated Quiet Area to ensure that the noise levels remain at a minimum and participants are not listening to music or watching television without the use of headphones. In-service will also include the posting of a Quiet Zone sign.

The "Daily Inspection Log" performed by the Administrator or designee, revised on October 9, 2025, to include a section for documenting the Quiet Zone sign is in place in the Quiet Area.

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PLAN OF CORRECTION (POC)

M 651 8:43F-14.10(a)(1)(c) Physical Plant Requirements (continued)

4. QUALITY ASSURANCE

The "Daily Inspection Log" is reviewed 6 (six) times a year as a part of the Quality Improvement Program by the Quality Improvement Committee (made up of the Nursing, Social Work, Activity Department Heads, and the Administrator). Verification that the Quiet Zone sign is in place in the Quiet Area reviewed at this time.

Annual review of in-services in November as part of the Quality Improvement Program using the "Review Employee Credentials and In-Services Using the Personal Information" to ensure that staff in-serviced regarding the ongoing expectations to maintain a respectful and peaceful environment of the Quiet Area and active monitoring the designated Quiet Area to ensure that the noise levels remain at a minimum and participants are not listening to music or watching television without the use of headphones, and posting of a Quiet Zone sign remains intact.

Completion Date: October 30, 2025 [redacted] approved 10/20/25

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PLAN OF CORRECTION (POC)

M 689 8:43F-14.17(f)(g) Physical Plant Requirements

1. CORRECTIVE ACTION

Fire drills from January 2024 to August 2025 were audited by Administrator and assistant on September 12, 2025. Exact date written on the Fire & Disaster Drill Log sheet and labeled as "date updated on 9-4-25." A list of all staff in attendance attached to the Fire & Disaster Drill Log.

2. IDENTIFY OTHERS

All clients in attendance had the potential to be affected by this practice.

Fire drills from January 2023 to December 2023 were obtained and audited to ensure that the exact date and all staff in attendance on those days were documented on or attached to the Fire & Disaster Drill Log.

3. SYSTEMIC CHANGES

The administrator will include specific dates and all participating staff on all Fire & Disaster Drill Logs.

The Evacuation Drills Policy amended on September 12, 2025, to include Administrator will document every drill on the "Fire & Disaster Drill Log" …including (MM/DD/YY) for exact date and more lines to include all staff members that participated.

"Fire & Disaster Drill Log" sheet updated on September 12, 2025, to including exact date (MM/DD/YY) and extra lines for all staff members that participated."

4. QUALITY ASSURANCE

Evacuation drills, including fire drills, will be reviewed annually as part of the Quality Improvement Program by the Quality Improvement Committee (made up of the Nursing, Social Work, Activity Department Heads, and the Administrator), to ensure that there is a specific date, and all participating staff members are documented.

Completion Date: 10-30-2025 [redacted] approved 10/29/25

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PLAN OF CORRECTION (POC)

M 701 8:43F-15.3(a)(1) Medical Records

1. CORRECTIVE ACTION

Participants #1, # 2, #3, and #4 electronic health records (EHR) updated to include photo of the client, signed participant rights, and emergency contact on September 12, 2025.

2. IDENTIFY OTHERS

All clients in attendance had the potential to be affected by this practice.

EHR audited September 5, 2025, for client photos, signed participant rights, and emergency contacts.

3. SYSTEMIC CHANGES

Utilization Review sheet, done monthly as part of the Quality Improvement Program by the Quality Improvement Committee (made up of the Nursing, Social Work, Activity Department Heads, and the Administrator), updated on September 5, 2025, to include the following:

Photo (due within 30 days from admission)
Participant Rights (due first day of admission)
Emergency contact (due first day of admission)

4. QUALITY ASSURANCE

The "Utilization Review" is reviewed annually as a part of the Quality Improvement Program by the Quality Improvement Committee (made up of the Nursing, Social Work, Activity Department Heads, and the Administrator).

Completion Date: December 03, 2025 [redacted] approved 10/29/25

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PLAN OF CORRECTION (POC)

M 805 8:43F-16.5(a)(b)(c) Infection Control, Sanitation, Housekeeping

1. CORRECTIVE ACTION

The administrator disposed of the paint cans from the Physical Therapy (PT) room on September 3, 2025.

The lighter fluid in the kitchen cabinet was removed and disposed of on September 3, 2025.

The administrator and kitchen staff locked the 3 (three) cleansers in the janitor's closet on September 3, 2025.

Kitchen staff, in-serviced on September 5, 2025, by the Administrator, policies titled Disposable Food Items and Daily Inspections to ensure labeling of all food items removed from their original packaging and confirm that all food items include an expiration date.

The kitchen staff labeled all food items removed from their original packaging that did not have the expiration dates on September 3, 2025. Undated food items were disposed of on September 3, 2025.

The boxes on the floor of the dry food storage closet were removed on September 3, 2025, from the floor and placed on an empty shelf allowing access to the lower shelves of the shelving units.

The passageway to the dry food storage closet was cleared of boxes and objects that were stored on the floor on September 3, 2025.

The administrator scheduled a contractor for floor and wall fixtures for October 24, 2025.

- two (2) large cracks on the wall of the social worker's office
- exposed sub-flooring and missing tiles on the floor of the women's restroom that was located across from the Quiet Area
- damaged walls and flooring in the women's restroom that was located across from the Quiet Area
- stained ceiling tiles in the Conference room
- dirt and dust on the base trim of the wall, next to the door of the Conference room
- NJ Ex Order 26. 4B1 of liquid on the wall that was next to the door of the Conference room.
- the light fixture located above the Quiet Area with debris present along the perimeter of the fixture's panels.

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PLAN OF CORRECTION (POC)

M 805 8:43F-16.5(a)(b)(c) Infection Control, Sanitation, Housekeeping (continued)

New light bulbs replace the two (2) sets of ceiling lights in the Conference room that had light bulbs that did not work on September 3, 2025.

Paneling covering the lights of the large light fixture, directly above the Quiet Area, are scheduled to be replaced on October 27, 2025.

The administrator scheduled a deep cleaning for the items below on October 24, 2025.

- white water cooler in the back of the facility
- two (2) long lights in the Conference room
- two ceiling fans above the Quiet Area
- removal of a string-like material draped over one of the fan's blades one (1) of the two (2) fans located above the Quiet Area
- dirt and dried liquid on the far wall and the closet doors in the Dining Room
- dirty kitchen floors and pipes, under the dishwashing sink in the kitchen

The plastic fork on the floor of the Dining Room was picked up off the floor and disposed of on September 3, 2025.

The unsecured extension cord that was hanging down the wall of the Conference room that was not plugged into a power outlet is now secured to the wall and plugged into a socket on September 3, 2025.

The power cord that was hanging down from a television and the plug was not attached to an outlet and was on the floor was plugged into the outlet on September 3, 2025.

Located in the Dining Room, the surge protector was suspended in the air, and the power cords were pulling it off the floor, replaced with a longer surge protector to eliminate it pulling off the floor on September 3, 2025.

Extension cord that was draped over the soap and paper towel dispensers in the Nursing Office was removed on September 3, 2025.

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Three (3) bicycles, a scooter, and a trash bin were removed from the Quiet Area on October 9, 2025.

PLAN OF CORRECTION (POC)

M 805 8:43F-16.5(a)(b)(c) Infection Control, Sanitation, Housekeeping (continued)

Clients directed that bicycles are to be store outside of the facility on October 9, 2025. A bike rack provided on September 12, 2025.

Administrator in-serviced on daily inspection checklist completion on September 12, 2025, by the Corporate Director of Nursing.

2. IDENTIFY OTHERS

All clients in attendance had the potential to be affected by this practice.

3. SYSTEMIC CHANGES

Kitchen staff in-service, by the Administrator or designee, on Infection Control-Disposable Food Items, including policies titled Disposable Food Items and Daily Inspections, to ensure labeling of all food items removed from their original packaging and confirming that all food items include an expiration date, increased to quarterly rather than biannually.

Daily inspection checklist in-service done by the Corporate Director of Nursing increased to quarterly instead of biannually.

Safety Committee made up of the Nursing, Social Work, Activity Department Heads, and the Administrator will take turns doing monthly audits of items listed on the Daily Inspections Checklist using the new form "Monthly Inspections Checklist." The new form "Monthly Inspections Checklist" developed on September 12, 2025.

4. QUALITY ASSURANCE

The "Infection Control- Daily Inspections Review" renamed to "Infection Control- Daily & Monthly Inspections Review" on September 12, 2025 currently reviewed quarterly increased to be reviewed 6 (six) times a year as a part of the Quality Improvement Program by the Quality Improvement Committee (made up of the Nursing, Social Work, Activity Department Heads, and the Administrator). Both the Daily Inspection Checklist and the Monthly Inspections Checklist will be reviewed at this time.

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Annual review of in-services in November as part of the Quality Improvement Program done by the Quality Improvement Committee (made up of the Nursing, Social Work, Activity Department Heads, and the Administrator) using the "Review Employee Credentials and In-Services Using the Personal Information" to ensure that

PLAN OF CORRECTION (POC)

M 805 8:43F-16.5(a)(b)(c) Infection Control, Sanitation, Housekeeping (continued)

kitchen staff in-service on Infection Control-Disposable Food Items.

Completion Date: November 30, 2025 [redacted] approved 10/29/25

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PLAN OF CORRECTION (POC)

M 807 8:43F-16.6(a) Infection Control, Sanitation, Housekeeping

1. CORRECTIVE ACTION

The Cleaning Schedule Policy & Procedure updated to include monthly and annual cleaning schedules on October 9, 2025.

All cleaning staff in-serviced by the Administrator, on October 9, 2025, on the updated Cleaning Schedule Policy & Procedure

2. IDENTIFY OTHERS

All the participants in attendance had the potential to be affected by this practice.

3. SYSTEMIC CHANGES

Annual Cleaning Schedule in-service now includes the updated Cleaning Schedule Policy & Procedure

4. QUALITY ASSURANCE

The biannual Infection Control Review-Cleaning Schedule Quality Improvement Review done by the Quality Improvement Committee (made up of the Nursing, Social Work, Activity Department Heads, and the Administrator) now includes the updated Cleaning Schedule Policy & Procedure.

Completion Date: October 30, 2025  approved 10/29/25

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PLAN OF CORRECTION (POC)

M 825 8:43F-17.1(c)(d)(e) Transportation Services

1. CORRECTIVE ACTION

Vehicle #1 has an updated inspection sticker on September 3, 2025.

Vehicles #2 and #3 are not in use and remain in the facility's private parking lot. Documentation was updated to estimate the last day of use. Vehicles #2 and #3 are not included in our fleet of working vehicles.

Drivers in serviced by the Administrator on September 5, 2025, on the Drivers policy, including their responsibility to get vehicles inspected timely.

All working vehicles inspected for updated inspection stickers on September 3, 2025.

2. IDENTIFY OTHERS

All the participants in attendance had the potential to be affected by this practice.

All working vehicles inspected for updated inspection stickers.

3. SYSTEMIC CHANGES

Drivers in-serviced by the Administrator, on the Drivers policy, including their responsibility to get vehicles inspected timely increased to quarterly from biannually.

The "Daily Inspection Log" performed by the Administrator or designee revised on September 5, 2025, to include a section for "Inspection stickers on vehicles up to date" checked at least monthly.

4. QUALITY ASSURANCE

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The "Daily Inspection Log" is reviewed 6 (six) times a year as a part of the Quality Improvement Program by the Quality Improvement Committee (made up of the Nursing, Social Work, Activity Department Heads, and the Administrator).

PLAN OF CORRECTION (POC)

M 825 8:43F-17.1(c)(d)(e) Transportation Services (continued)

Annual review of in-services in November as part of the Quality Improvement Program done by the Quality Improvement Committee (made up of the Nursing, Social Work, Activity Department Heads, and the Administrator) using the "Review Employee Credentials and In-Services Using the Personal Information" to ensure that drivers in-serviced regarding Drivers policy, including their responsibility to get vehicles inspected timely increased to quarterly from biannually.

Completion Date: October 30, 2025 [redacted] Approved 10/29/25

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
558100 Y1	A. Building B. Wing Y2	10/29/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE ADULT DAY HEALTH CARE CENTER	600 MAIN STREET ASBURY PARK, NJ 07712

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix M0235 Reg. # 8:43F-3.3(d)(1) LSC	Correction Completed 10/30/2025	ID Prefix M0351 Reg. # 8:43F-4.2(d) LSC	Correction Completed 10/30/2025	ID Prefix M0393 Reg. # 8:43F-6.1(b) LSC	Correction Completed 09/05/2025
ID Prefix M0423 Reg. # 8:43F-6.3(f) LSC	Correction Completed 10/30/2025	ID Prefix M0619 Reg. # 8:43F-14.4(b) LSC	Correction Completed 10/30/2025	ID Prefix M0633 Reg. # 8:43F-14.6 LSC	Correction Completed 10/30/2025
ID Prefix M0645 Reg. # 8:43F-14.9(b)(1-3) LSC	Correction Completed 10/30/2025	ID Prefix M0651 Reg. # 8:43F-14.10(a)(1)(i) LSC	Correction Completed 10/30/2025	ID Prefix M0689 Reg. # 8:43F-14.17(f)(g) LSC	Correction Completed 10/30/2025
ID Prefix M0701 Reg. # 8:43F-15.3(a)(1) LSC	Correction Completed 12/03/2025	ID Prefix M0805 Reg. # 8:43F-16.5(a)(b)(c) LSC	Correction Completed 11/30/2025	ID Prefix M0807 Reg. # 8:43F-16.6(a) LSC	Correction Completed 10/30/2025
ID Prefix M0825 Reg. # 8:43F-17.1(c)(d)(e) LSC	Correction Completed 10/30/2025	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/3/2025	☐ YES ☐ NO