STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	558100	A. BUILDING: _____ B. WING _____	C 04/04/2024

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

(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
M 000	Initial Comments Type of Survey: Complaint Complaint #: NJ00172457 Census: 89 Sample Size: 3 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 265	8:43F-3.4(a)(6) Administration (a) The facility shall notify the Department immediately by telephone at 609-633-9034 (609-392-2020 after business hours), followed by written confirmation within 72 hours of the following: 6. All alleged or suspected crimes committed by or against participants, which shall also be reported at the time of occurrence to the local police department.	M 265		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 265	Continued From page 1	M 265		

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ00172457

Based on interview and record review, it was determined that the facility failed to immediately report to the Department of Health (DOH) NJ Ex Order 26.4b1 which resulted in NJ Ex Order 26.4b1 for 1 of 3 participants reviewed, Participant #2. This deficient practice was evidenced by the following:

On 4/4/24, at 9:30 a.m., the Department of Health (DOH) investigated a Reportable Event Report (RER) received from the facility on NJ Ex Order 26.4 which occurred on NJ Ex Order 26.4. The RER revealed, "... Client A reported that he/she was NJ Ex Order 26.4b1 by another client (Client C)... Client A reported NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. "NJ Ex Or" was called. EMS arrived and tended to Client A's NJ Ex Order 26.4b1. NJ Ex Order 26.4b1 to that area noted by nurse .... RN [Registered Nurse]. Client A was NJ Ex Or and NJ Ex Order 26.4b1, rated NJ Ex Or at NJ using a NJ Ex Order 26.4b1. No NJ Ex Order 26.4b1 NJ Ex Order 26.4 NJ Ex Order 26.4b or NJ Ex Order 26 recorded. Client A NJ Ex Order 26.4 to go to the Emergency Department. Client C exited the facility prior to the arrival of the NJ Ex Order 26.4

At 10:55 a.m., the surveyor interviewed the Director of Nursing (DON) who stated that on NJ Ex Order 26.4 at approximately 2 p.m., she responded to NJ Ex Order 26.4b1 and was informed that Participant #1 who NJ Ex Order 26.4b1 Participant #2 NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. The DON stated the Emergency Medical Service

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

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M 265	Continued From page 2 (EMS) and the NJ Ex Order 26.4b1 were called. The DON stated Participant #2 NJ Ex Order 26.4 to go to the emergency room and was assessed and treated at the scene by the EMS. The DON stated Participant #1 left the scene before a NJ Ex Order 26.4b1 arrived. At 12:20 p.m., the surveyor interviewed the Administrator regarding the NJ Ex Order 26.4b1 with NJ Ex Order 26.4b1. She stated Participant #2 came to her office NJ Ex Order 26.4b1 and stated he/she was NJ Ex Order Participant #1 after an NJ Ex Order 26.4b1. The Administrator stated she called EMS and the NJ Ex Order 26.4b1. In addition, the Administrator stated she escorted Participant #1 to the lobby who left the premises before a NJ Ex arrived. Participant #2 was not available for interview. During continued interview, the surveyor then, asked the Administrator if the NJ Ex Order 26.4b1 was reported to the DOH. The Administrator confirmed the incident was not reported immediately and was faxed to the DOH on NJ Ex Order 26.4, NJ Ex Order 26.4b1 later. On 4/8/24 at 12:03 p.m., the surveyor reviewed the NJ Ex Order 26.4b1 dated NJ Ex Order 26.4 which indicated a NJ Ex Order 26.4b1 responded to the Adult Day Center on NJ Ex Order 26.4 at 13:29:28 p.m., [1:29 p.m.,] in reference to a "NJ Ex Orde." The NJ Ex documented Participant #2 stated he/she got into a NJ Ex Order 2 with Participant #1 at the NJ Ex Order 26.4b1 and Participant #1 NJ Ex Order 26.4b1 [Participant #2] with a NJ Ex Order 26.4b1. The NJ Ex Order 26.4b1, at the NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 at the NJ Ex Order 26.4b1.	M 265		

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M 265	Continued From page 3 The facility failed to notify the DOH immediately by telephone followed by written confirmation within 72 hours of the aforementioned incident.	M 265		
M 579	8:43F-12.2(a) Social Work Services The facility shall arrange for the provision of social work services to participants who require them, in accordance with N.J.S.A. 45:15BB-1 et seq. and N.J.A.C. 13:44G. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00172457 Based on observation, interview and record review, it was determined that the facility failed to ensure that a licensed or Certified Social Worker was available to provide social work services to the participants who required such services. This deficient practice was evidenced by the following: On 4/8/24 at 10:55 a.m., during interview with a Registered Nurse (RN), the surveyor inquired and requested to speak with a Social Worker (SW) regarding NJ Ex Order 26.4b1 [redacted] that occurred at the facility on [redacted]; and in addition, inquired about participants' discharge planning. The RN informed the surveyor that the facility did not have a SW and was not sure of the SW's last date of employment. At 12:20 p.m., during interview with the Administrator regarding the facility's SW, the	M 579		

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M 579	Continued From page 4 Administrator stated that the facility has not had a SW for a couple of weeks. She explained that the SW's last date of employment was [NJ Ex Order 26.4b1] and was in the process of hiring a SW. Surveyor review of the SW's "Megapay," a payroll sheet provided by the Administrator confirmed that the SW's last date of employment was [NJ Ex Order 26.4b1]. The facility did not have a licensed or certified SW available for the participants that may have required such services and did not have a SW from [NJ Ex Order 26.4b1] to survey date of 4/4/24.	M 579		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
558100 Y1	A. Building B. Wing Y2	5/17/2024 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 M0265 Reg. # 8:43F-3.4(a)(6) LSC	Correction Completed 04/26/2024	ID Prefix M0579 Reg. # 8:43F-12.2(a) LSC	Correction Completed 04/26/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
4/4/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO